Case management for long-term and acute medical care

by John A. Capitman

Case management has developed as an administrative service for controlling costs and improving the quality of health and social service delivery. Long-term care case management combined with service expansion has been examined in some detail with varied results. Less research has focused on case management for users of high-cost medical care. This overview highlights five programs and patient groups where integrated delivery and/or financing of medical and long-term care services are being demonstrated and where new roles for case management may be indicated.

Introduction

Case management has been defined as an administrative service that directs client movement through a series of phased involvements with the health and social service delivery system with the goal of increasing the quality and cost effectiveness of care (Capitman, Haskins, and Bernstein, 1986). Case management (CM) programs have been embedded in diverse delivery systems, serving a variety of populations including long-term care users, users of high-cost medical care, and mental health or substance abuse program participants. The five articles presented in this section discuss new CM approaches in the context of long-term care for Medicare beneficiaries and users of high-cost medical care.

General assessment of CM program impacts has been complicated both by the variety of applications of the concept and inconsistent language. The terms "case management," "care management," and "care coordination" have been used to describe mechanisms for utilization and cost control such as preadmission certification, second surgical opinion, or physician gatekeeper programs. These mechanisms may be components of CM systems and some, such as second surgical opinion, have received considerable attention. But the comprehensive models discussed in the five articles in this section involve more than strategies to track utilization and control access to care (Henderson et al., 1988). Both medical and long-term care CM programs usually contain at least the following components: intake/eligibility determination, needs assessment, care planning, service arrangement, monitoring, and termination planning (Capitman, 1986; Henderson, Souder, and Bergman, 1987; Merrill, 1985).

Although some analysts suggest that CM programs should be promulgated because of their potential influence on the quality of life experienced by clients, most research has viewed CM programs in the context of increasing the cost effectiveness of appropriate and coordinated health and long-term services. From this latter perspective, two issues have dominated discussions of CM programs in both acute medical and long-term care applications. First, in order to have an impact on the quality and cost effectiveness of care, CM programs must be targeted to individuals whose patterns of care can be influenced. CM researchers continue to explore alternative approaches to identification of appropriate target groups. Second, because CM is a relatively new service, there are broad variations in staffing and task configurations, clinical procedures, scope of authority, and other major program design features. Understanding the implications of these differences among CM approaches remains a major focus of research and demonstration efforts.

Long-term care

Long-term care CM has received considerable attention in the context of the Medicare and Medicaid demonstrations of Coordinated Community-Oriented Long-Term Care, the National Long-Term Care Channeling Demonstration, the Medicaid Home and Community-Based Care programs, and other efforts (Capitman, 1986; Kemper, Applebaum, and Harrigan, 1987; Yeatts, Capitman, and Steinhardt, 1987; Capitman, Arling, and Bowling, 1987). The demonstrations varied considerably in terms of goals, target group definitions, sponsoring organizations, and host community characteristics. CM approaches varied as well from the perspectives of staffing, operational structure, and costs. Yet in all of these programs, CM was combined with some expansion of public financing for community-based long-term care, with the goal of reducing public cost and improving the responsiveness and appropriateness of care through substitution of community care for nursing home, hospital, and skilled home health services.

Many of these studies find it difficult to identify chronically ill and functionally disabled elders for whom the provision of CM and expanded services results in reduced use of currently covered nursing home, acute medical, or home health services. As a result of the failure in most studies to show substitution or diversion impacts, cost effectiveness is rarely demonstrated. The two exceptions appear to be programs that used preadmission screening of Medicaid patients seeking entry to a nursing home as the intake/eligibility process for CM and expanded services, and programs that combined State Medicaid nursing home admissions criteria for targeting CM with hospital-based transitional care programs or consolidated delivery systems. Results on mortality,

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morbidity, satisfaction with care, and other potential measures of quality enhancements resulting from CM have been generally favorable, but are neither consistent nor conclusive. These findings suggest that tightly targeted CM programs, offered in the context of other clinical, management, and financing reforms, can meet the objectives for which they were implemented.

Based on these findings, the focus of research and demonstration efforts related to long-term care CM has shifted. There is ongoing interest in Medicaid 2176 home- and community-based care programs that attempt to use CM and expanded services as substitutes for nursing home care. At the same time, there is a new recognition of the financial burdens of long-term care on the elderly and of their preference for coordinated provision of medical and long-term care. Integrated health and social service delivery and financing approaches based on capitation payments to comprehensive providers are viewed as one set of strategies. Two of the articles included in this section discuss CM in the context of such integrated delivery systems.

Early evaluation findings about the roles and operations of CM in the social health maintenance organization demonstration are discussed by Yordi. In this demonstration, a broad cross-section of elders is offered a service package including traditional Medicare benefits and a broad array of institutional and community long-term care services. The long-term care benefits are limited in duration and quantity, and CM functions include control of this benefit and coordination of the linkages between acute medical and long-term care. Zawadski and Eng discuss CM approaches in the Community Care Organization for Dependent Adults as developed by On Lok Senior Health Services. At On Lok, and at the planned replication sites, comprehensive health and long-term care are provided to elders who qualify for nursing home care. CM approaches are notably different in this model, because the program is both provider and manager of most care.

Case management in medical care

Far less attention has been focused on the techniques or impacts of medical care CM programs, and experimental analyses of cost effectiveness are not available. There is, however, considerable evidence that, within a population, large proportions of total medical costs are associated with high levels of use by a small minority (Zook and Moore, 1980). Among Medicare beneficiaries, there is some evidence that catastrophic levels of use are more prevalent with particular diagnostic patterns and associated hospital readmissions (Gooding and Jette, 1985).

There are clear gaps, however, in our understanding of the determinants of high-cost use of medical care by elders or the relationships between this use and the need for long-term care services. There is little basis then for targeting medical case management tosubgroups among the elderly, or for linking acute and long-term care management programs. Eggert argues that CM approaches and service expansions developed in the context of long-term care programs can be targeted to elders who are high-cost users of hospital care by focusing on three subgroups: nursing home residents with acute exacerbations of chronic illness, elders admitted to hospitals from the emergency room, and elders with a prior history of extremely high levels of medical care use.

Similarly, for other age groups there is evidence that extremely high-cost use of medical care is associated with specific medical conditions, such as acquired immunodeficiency syndrome (AIDS), certain cancers, and spinal cord injuries. However, the potential for increasing quality and cost effectiveness of care by targeting CM and changes in third-party coverage to particular users is only now receiving research attention. For example, Section 425 of the Medicare Catastrophic Coverage Act of 1988 calls for four large-scale demonstration and research projects examining different CM models targeted to Medicare beneficiaries with selected catastrophic illnesses.

Some of the CM design features that may be required for these Medicare users with catastrophic costs are suggested in the article describing CM in the context of private insurance. Henderson points to program features such as service substitution and other changes in the scope and duration of particular benefits. It is also noteworthy that it may be easier to demonstrate CM impacts on the coordination and acceptability of services than on total costs of care, even with more tightly targeted approaches.

The variety of CM approaches that may both be needed and developed for high-cost medical users is also described in Benjamin's article on CM for AIDS patients. At different stages in the progress of the disease, AIDS patients may require coordination of medical care, mental health services, or long-term care services, as well as assistance in accessing other public and private benefits. Benjamin notes that CM programs ranging from very formal and tightly targeted to informal and highly idiosyncratic have emerged in San Francisco to meet these diverse needs. These systems may evolve in the direction of greater formality as the patient group grows and there is increased appreciation for the role of CM in management of transitions in medical and other service needs.

The articles presented together suggest some of the major areas for potential cross-fertilization between demonstrations of long-term and medical CM programs targeted to other populations. In particular, two important challenges for CM programs and research are stressed: how best to coordinate medical care delivery and long-term care delivery in diverse populations, and how best to allocate both CM services and other service enhancements or substitutions as client needs change.

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