Integrating Geriatric Case Management into Primary Care Physician Practices

As the delivery of health and human services has become more complicated, fragmented, and expensive, case management has gained popularity. Various case management models have emerged in social work (Loomis, 1987), nursing (Gerber, 1994; Swindle, Weyant, & Mar, 1994), and medicine (Like, 1988). Multiple population groups are being served, and practice guidelines have been published (Geron & Chassler, 1994; Kaye, 1992).

Geriatric case management targets frail clients who are at risk of being high consumers of health care services. Case managers who work with elderly clients often come into contact with primary care physicians and a plethora of other health care providers. The case manager's involvement may vary from just knowing the name of the client's physician to being directly involved in the physician's practice (White, Gundrum, Shearer, & Simmons, 1994).

Relationships between physicians and social workers have been studied as an acute care interaction with discharge planning elements (Mizrahi & Abramson, 1994). However, as health care services move more and more into community-based settings, the potential conflict and need for collaboration between social work case managers and physicians also move. Some group practices are using social workers (Kramer, Fox, & Morgenstern, 1992). In addition, nurses, physician's assistants, and other health care personnel are assuming expanded roles in geriatric case management.

Relationships between social workers and physicians date back to the early years of the profession. In 1919 the physician who appointed the first full-time paid social worker at Massachusetts General Hospital reported, "I needed information about the patient which I could not secure from him as I saw him in the dispensary—information about his home, his lodgings, his work, his family, his worries, his nutrition" (Cabot, cited in Mullaly, 1988, p. 5). This description reveals acknowledgment of the physician's need to view the person in his or her environment and the importance of the social worker's role in assessing home- and community-based factors.

Today older people continue to turn to primary care physicians for assistance with their concerns and problems. However, cost pressures and the growth of managed care limit the time physicians can spend with patients. As physicians encounter more and more older patients, they often question just how far the scope of their medical practice extends into the broader social, economic, and environmental problems of their patients. It is too easy for physicians to limit their attention to monthly 15-minute office visits that are focused on medications to relieve symptoms.

It is out of such changing and complex health care environments that demonstration projects emerge. The project reported here reflects the larger issues of health care delivery and the potential for collaboration between physicians and geriatric case managers.

PROJECT Background

In 1992 the John A. Hartford Foundation's Generalist Physician Initiative was started. Between 1992 and 1993, nine demonstration sites were funded across the United States. These projects were designed to enhance primary care physicians' care of frail elderly people by integrating geriatric case managers and caregivers into their practices. Although each site was required to have a well-designed evaluation, it was not mandated that each site use identical tools to measure outcomes or select patients in exactly the same way. Each site designed its own intervention; for example, in New Hampshire physicians were supported with educational resources so that they could become their
own case managers, and in other projects various professionals (nurses, nurse practitioners, social workers, physician assistants, and paraprofessionals) acted as intervention agents. Depending on the credentials of each agent, roles and responsibilities varied. For example, nurse practitioners in inner-city Detroit remained clinic based, whereas para-professionals in South Carolina visited rural elderly people in their homes. Most sites did not call their invention “case management,” although many of the roles assumed by the professionals included case management. Terms such as “care coordinator,” “geriatric specialist,” and “senior care assistant” were used.

Within this larger initiative, the authors were asked to evaluate the demonstration site in Albuquerque, New Mexico. The Albuquerque metropolitan area has about 600,000 people, 15 percent of whom are elderly. The grantee was the St. Joseph Healthcare System, which is a member of the Sisters of Charity Health Care Systems based in Cincinnati. The demonstration was named the Coordinated Care Partnership.

In November 1991, St. Joseph initiated MED-NET, a hospital-sponsored multispecialty group practice. To foster collaboration with primary care physicians in the process of caring for elderly people, St. Joseph used the Hartford monies to implement an enhanced case management system in partnership with selected MED-NET physicians. Three MED-NET physician practices, with three to four physicians each, were selected for case management intervention.

**Patient Selection and Screening**

Physicians agreed on criteria for selecting patients for the program based on their judgment of who would most likely benefit from case management. Patients were required to be age 65 to 80 at the date of entry and to have been diagnosed with one or more of the following: congestive heart failure, cerebrovascular accident, diabetes, chronic obstructive pulmonary disease, and hip fracture. Lists of patients who met the criteria were identified by office staff at each physician practice.

Rather than completing a formal in-person assessment of every patient who met the criteria, a three-step screening process was implemented to target case management efforts on those most in need. First, identified patients were initially screened by a case management assistant through a telephone interview. Screening sought to identify self-reported limitations in activities of daily living and risk of falls; appointments with other physicians; weight loss or gain of more than 10 pounds; the use of an ambulance, emergency room, or urgent care center; the number of medications taken in the past year; the completion of advance directives for health care; the frequency and quality of contact with family members; the presence of sleep disorders; and indicators of depression.

Second, on the basis of the results of the screening process, a case manager visited those patients with potential needs. Among this group, active case management was initiated for 146 patients between March 1993 and June 1994. These patients received more than 4,000 case management contacts (including home visits and telephone contacts) resulting in almost 3,000 hours of service. Third, 95 patients were determined not to need in-home assessment at this point and were to be called again in three months to see if their situations had changed.

**EVOLVING CASE MANAGEMENT MODEL**

Originally, two social workers with master of social work degrees and two registered nurses were hired as case managers. Once the case management assistant had screened the patients, she referred those who needed in-home assessments to the case managers. At first, a nurse teamed with a social worker to jointly conduct the assessment, which provided an opportunity for the case managers to learn from one another. Once a care plan was established, the client was monitored by a case manager. Because this project was originally conceived as a brokerage model, monitoring did not include providing direct care. The case managers coordinated services, reassessed clients, and followed up as more services were needed.

**Challenges**

Over the past two years, a great deal has been learned in this project. First, it soon became clear that professionals who served as case managers could do more than oversee coordination. As we conducted site visits and interviewed project staff, case managers indicated that sometimes they did “direct care.” Direct care for nurses included taking blood pressure, listening to breathing, and assessing skin changes. Social workers provided some counseling and worked with families. Case managers were frustrated because they were not using their professional skills.
Second, as caseloads increased it became harder for the nurse-social worker team to do every in-home assessment together. Multidimensional in-home assessments were time consuming and labor intensive. Social workers could confer with nurses and vice versa, but it was not always possible for both to conduct assessments.

Third, the case managers were located in a separate office building from the physicians’ practices. Also, MED-NET physician office suites were small, with insufficient space for case managers. Communication was done by telephone, fax, and occasional conferences. This approach did not allow any sense of relationship to develop between the physicians and case managers. The physicians’ office staff were in contact with case managers as they called in and sent reports, yet the sense of integration that was intended was not occurring. Case managers and physicians alike did not feel they really knew one another, and the physicians were not always certain what role the case managers played.

Fourth, the case management assistant had become a gatekeeper for the case management services; she alone determined if patients needed an in-home assessment. This responsibility placed a great deal of pressure on each individual. Combined with this pressure was the fact that physicians would occasionally directly refer a patient who did not meet any of the established criteria. Case managers faced with this situation were reluctant not to follow through because they needed to establish relationships, and these scenarios were seen as opportunities to prove their worth.

Changes
These findings have been used to redesign the Albuquerque model so that it better meets the needs of physicians, case managers, and patients in its third year of operation. A move was made to focus on social work roles and to give case managers the flexibility to provide limited direct care. Some counseling became acceptable as a logical outgrowth of developing a relationship with an older client. Essentially, a modified brokerage model emerged. Because the nurse case managers left to take positions where their nursing skills could be used, new hires were social workers. These changes obviously reduced the in-home assessment practice of working as a team. Case managers can consult with other professionals, but they now conduct their own in-home assessments.

A major alteration came when case managers were assigned to specific physician practices. Experience with other sites around the country revealed that proximity was a critical factor in establishing trust and developing ongoing relationships that might persist once grant monies ended. Case managers and physicians began to get to know one another for the first time; as they met one another in the hallways, they had opportunities for face-to-face interaction. This transition was probably the most critical change in program design.

Office staff worked with case managers to locate space. In one office, for example, the case manager took an office vacated by a physician. In another, the case manager shared space with another staff person.

With the proximity change came a new set of opportunities surrounding patient referral and interaction. Case managers began receiving “quick response” referrals from physicians. For example, a patient would be seen who had multiple problems, and the physician could turn to the case manager for assistance. This was completely different from the original process, in which a list of names had been generated and a screening had to occur. This change had tremendous implications for the case management assistant who was still located in an office separate from any of the practices. Her role evolved into assisting the case managers in making calls, following up on referrals, getting paperwork completed, and so forth. Her gatekeeping role was transformed into a supportive role for busy case managers who were trying to respond quickly to patients in immediate need.

When case managers came into closer contact with physicians, they realized that their carefully prepared monthly reports had been somewhat ignored. Each month case managers had prepared a summary on each client they were seeing and had forwarded it to the physicians’ offices. In one practice, these reports had never been filed, not because the physicians and their staff did not care, but because they were already inundated with paperwork. Now case managers can communicate verbally and make short, meaningful notes for physicians to place in their patients’ charts.

CONCLUSION
The message from the evaluators of the Albuquerque project is that the best-designed projects will always change. What is written on paper is only a beginning step in project implementation. Alterations in program design and reasons for these changes are as important to share as the factors that worked as originally designed.
REFERENCES


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