Long-Term Care Case Management: A Look at Alternative Models

Robert Applebaum, PhD, Pamela Mayberry, MS
Case management has increased substantially and is now an integral component of the home care system in the United States. Although case management has been implemented in home care programs since the 1970s, the core components of the intervention have remained unchanged. Standardization of practice can be important; however, it is also necessary for care paradigms to be modified as the health and long-term care systems change. This article presents alternative approaches to delivering case management now being tested in two home care programs funded through community property tax levies.

Key Words: Alternative case management, Community based long-term care, In-home case management

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Some years ago at a national conference, we asked a colleague to introduce our session on case management. His introduction included the following excerpt:

Reuters News Service, Dateline: Cairo Egypt
Archaeologists today uncovered the remains of a person whom they believe to be history's first case manager. Archaeologists believe that the woman became lost in a sandstorm on her way home from a meeting with a group of nomad providers. They speculate that she was trying to convince the providers to use her comprehensive assessment. Archaeologists theorize that she was crushed to death under the weight of her hieroglyphic assessment tablets (Callahan, 1985).

Although the facts of this story may be in dispute, this account highlights the point that many of the core elements of case management have long been important to health and social services practice. Key elements of case management such as comprehensive assessment, systematic plan of care, and ongoing case monitoring have clearly become part of established practice in working with a chronically disabled population.

The roots of modern day case management in long-term care can be traced back to a series of home care demonstrations that began during the early 1970s (Kemper, Applebaum, & Harrington, 1987; Weissert, Cready, & Pawelak, 1988). Since that time, there has been an explosion in the use of case management. Over 20 home care demonstrations have tested the use of case-managed in-home care. The passage of the Section 2176 Medicaid waiver by Congress allowed states to use the traditional Medicaid program to fund in-home care (Burwell, 1994); these waivers require the use of case management to arrange and monitor the benefit. In conjunction with an array of state-funded home care programs, virtually every state in the union provides some level of case-managed in-home long-term care (Justice, Folkemer, Donohoe, & Nelson, 1991). Private long-term care insurance carriers and networks of corporate benefit plans are now establishing long-term case management across the U.S. as well. Combining these trends with efforts to expand the case management approach, it seems clear that case management will remain a viable component of the home care environment (Justice et al., 1991; Applebaum, in press). In this article, we describe a model developed in two communities that have implemented an alternative approach to delivering case managed in-home care.

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The Case for an Alternative Model

As practice strategies develop they typically go through a series of evolutionary steps, resulting in a more structured intervention. Training regimens are designed, professional standards are proposed, and individual or organizational certification or licensing plans are proposed as an intervention evolves. Although the establishment of a stable set of core case management functions certainly makes sense, standardization of the long-term care case management intervention does pose one danger: as the delivery system changes, because of its emphasis on standardization, the case management component does not. The dominant model of long-term care management in the U.S. has included a comprehensive assessment and care planning process involving both the formal and informal system. Typically, all home care recipients are required to receive case management. State and federal programs have allowed little flexibility in the design and use of case management.

Demographic projections concerning the size and scope of the future long-term care population indicates that the need for case management and in-home care will likely continue (Snow, 1995; Shapiro, 1995). However, the case management intervention that has been adopted across the nation is labor intensive (requiring a low case manager to client ratio in order to implement the model as designed), targeted toward a small segment of the disabled population, and can take weeks for care plan implementation following assessment. Questions raised about long-term care case management include whether this is the optimum model to use in delivering in-home care, whether the in-home care system can afford this level of intensity, and whether a home care system should be more preventative in nature.

The case management intervention thus receives mixed reviews. On one hand, it is seen as an important mechanism to coordinate the many services, providers, and activities that have been traditionally fragmented in the existing health and long-term care system. It provides an approach that systematically assesses a broad spectrum of individual needs, rather than being focused on a particular need or service area, and involves the consumer and his or her family in the development of the plan of care. The intervention includes an important monitoring component in an effort to assure the quality of in-home care, as well as to identify risks to the client resulting from changes in health or social support systems.

On the other hand, the case management intervention is labor intensive with costs around $100 per client per month (Applebaum & Austin, 1990). Because of the complexity of the assessment and care planning process, case management is not a quick turn-around intervention. There have also been concerns raised by individuals about the case management design. As long-term care has expanded to the under-65 population, particularly to adults with physical disabilities, the concept of case management has been consistently criticized for not emphasizing the independence and autonomy of the care recipient.

The Ohio Programs

As a result of the Medicaid waiver, the expansion of state home care programs, and the growth of Medicare home health, the array and number of in-home services has been expanded. What is not clear is whether these additional services are organized in a manner that creates a rational system of in-home care. In response to this concern, Ohio initiated the Options for Elders demonstration project from 1989–1991. This initiative was designed to develop a coordinated service system that provided both access and service coordination for those needing in-home care.

Following the completion of the demonstration, citizens in the urban Franklin County-Columbus site decided to attempt to continue the program through local funding. After securing some 50,000 citizen signatures, a property tax referendum to fund in-home care was placed on the general election ballot. With 68% of the vote, a five-year $10.4-million-a-year levy was passed to fund case managed in-home care for elders through the Franklin County Senior Options program. Based on this success, a second county, Hamilton-Cincinnati, took a similar proposition to the voters, securing a five-year $12.7 million-per-year levy for the Elderly Service Program (ESP). Each program currently provides funding, assessment, coordination, and monitoring of home care services for about 4,000 older adults.

Using a triaging model, the Ohio programs are set up to be the single entry point for information and access to services for all older community members needing any type of long-term care assistance. A large number of calls are for information and assistance only. For example, in 1993, of the 18,438 calls to the Franklin County program, about 80% were in the information category. The Hamilton County site continued to rely on the network of service agencies to provide some of the information and assistance, resulting in about one third of their calls being in the information-only category.

Although neither of the programs pay for skilled home care traditionally funded under Medicare or Medicaid, they do fund an array of services, including homemaker, personal care, adult day care, respite care, home-delivered meals, medical transportation, medical equipment, and home maintenance and repair. In both programs, home-delivered meals, homemaker services, personal care, and respite care comprise approximately 80% of the total service budget.

Multi-Level Case Management

Based on an initial telephone assessment, callers are assigned to either a Basic, Ongoing, or Case Management level of care (see Table 1). Individuals determined to need moderate levels of assistance are assigned to the Basic or Ongoing Assistance categories. Basic Assistance is designed for those determined to need short-term services (6 to 8 weeks or less). Following the telephone assessment, service needs are verified by the provider agency, but no
The two programs handle this piece of the intervention in different ways. In Franklin County, the telephone assessment is incorporated into the intervention. In about 75% of the cases, services are ordered based solely on the telephone assessment, relying on the providers to verify the assessment. Ongoing clients in the Hamilton County program are also monitored by telephone; however, they receive a 6-month home visit in addition to the annual reassessment.

In-person assessment is completed by the care management agency. All case management activities, including service arrangement, monitoring, and termination are done by telephone. In instances where the client appears to need more care or services for a longer period of time, the case is transferred to one of the other case management categories. Case managers are most often licensed social workers, although some are registered nurses and nursing consultation is incorporated into the intervention.

Ongoing Assistance is designed for those who need services for a longer period of time, but who require a low-intensity level of case management. The two programs handle this piece of the intervention in different ways. In Franklin County, the telephone screen is verified in every case via an in-person assessment. If the telephone assessment of service needs and the Ongoing Assistance level classification is confirmed, the individual is monitored by telephone until a one-year annual review is done in person. In Hamilton County, only those applicants with special circumstances (such as communication problems, complicated service needs, or unstable family or caregiver situation) would receive an in-person assessment following the telephone screen. In about 75% of the cases, services are ordered based solely on the telephone assessment, relying on the providers to verify the assessment. Ongoing clients in the Hamilton County program are also monitored by telephone; however, they receive a 6-month home visit in addition to the annual reassessment.

Individuals who have more extensive service needs or who require more intense monitoring or care management are assigned to the Case Management level. Following the more traditional model, case managers in this component review the initial screen, visit the client at home to complete an in-depth assessment, and develop a comprehensive plan of care with the consumer and their family. Formal monitoring through telephone calls and in-home visits is done throughout the service period.

### Client Characteristics

Characteristics of clients in each of the three categories appear as expected. Clients in the Case Management category are older, more functionally impaired, and have higher service expenditures than those in the other two groups. Although some differences exist between the Basic and Ongoing groups (Ongoing clients are likely to be older), in general the two groups have similar characteristics. Despite the expected overall differences in functioning for Case Managed clients and others, there are a number of non-Care Management clients with high levels of disability and high service needs. For example, over 15% of clients in the Ongoing group have four or more ADL impairments. Conversely, some Care Management-level clients have mild functional impairments (IADL-impaired only) and receive limited services (less than $150 per month). Thus, levels of assistance are based on a series of factors in addition to functional ability, including the clients’ and/or their families’ previous experience with service delivery systems, personality characteristics (such as desire to be involved in the care management process), stability of health status, and presence or lack of support systems. In more traditional practice, functional ability is the general determinant used to allocate case management.

Another indicator of the intensity of case management is the number of program services received by the client. Data on the number of services received in the Hamilton County program showed that the Basic clients were most likely to receive one service (86%), typically transportation or home-delivered meals. About 60% of the Ongoing client group received one service, while just over 13% received 3 or more.

### Table 1. Case Management Intervention and Client Characteristics (Hamilton County)

<table>
<thead>
<tr>
<th>Case Management Levels</th>
<th>Age</th>
<th>% with 4 or more IADL Impairments</th>
<th>% with 2 or more ADL Impairments</th>
<th># Services</th>
<th>% Receiving</th>
<th>Service Cost (excludes cost of case management)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of Total Clients &amp; Intervention Description</td>
<td>% 80+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Average Monthly $</td>
</tr>
<tr>
<td>Basic (3% of all clients)</td>
<td>29</td>
<td>78</td>
<td>50</td>
<td>1</td>
<td>86</td>
<td>213</td>
</tr>
<tr>
<td>• Telephone assessment only</td>
<td></td>
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<tr>
<td>• Telephone case management</td>
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<td>• Short-term (&lt;6 weeks)</td>
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<tr>
<td>Ongoing (90% of all clients)</td>
<td>43</td>
<td>78</td>
<td>42</td>
<td>1</td>
<td>61</td>
<td>192</td>
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<tr>
<td>• Telephone assessment with in-person follow-up only if needed</td>
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<td>• Telephone case management</td>
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<tr>
<td>• Annual in-home assessment</td>
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<tr>
<td>Care Managed (7% of all clients)</td>
<td>50</td>
<td>98</td>
<td>79</td>
<td>1</td>
<td>24</td>
<td>484</td>
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<tr>
<td>• Telephone and in-person assessment</td>
<td></td>
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<tr>
<td>• Traditional service coordination and monitoring</td>
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</tr>
<tr>
<td>• Semi-annual in-home assessment, plus periodic visits</td>
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<td></td>
<td></td>
<td>3 or more</td>
<td>44</td>
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</tr>
</tbody>
</table>

Note. Table based on Hamilton County program, approximately 3,400 clients, July 1995.
services. Just less than one quarter of the Case Management group received one service, with almost half (44%) receiving 3 or more project services.

Monthly service costs, excluding case management, averaged $213 for Basic, $192 for Ongoing, and $484 for Case Managed clients in the Hamilton County program. In addition to service expenditures, the costs associated with the varying levels of care management were examined. Although unavailable for Hamilton County, data for Franklin County identified Basic and Ongoing case management costs at about $45 per month, compared to just under $90 per month for the Case Managed group (Applebaum, Ciferri, Riley, & Molfenter, 1991).

Although costs are an important factor in the design of any intervention, the quality and effectiveness of care are the ultimate concern. Two areas of quality have been examined in looking at the levels of case management: 1) quality of telephone assessment and the resulting plan of care and 2) timeliness of initiation of services. Two clinical studies have addressed telephone assessment and care planning. A 1991 evaluation of the Senior Options demonstration found that telephone assessment and service arrangement resulted in an accurate assessment of need and an appropriate level of care. After reviewing assessment data, plans of care, and service utilization data, reviewers reported that the appropriateness of the services for those who received telephone assessments did not appear to be different from that of those receiving the in-person assessment (Applebaum et al., 1991). In a more recent study in the Hamilton County program, clients who had received only the telephone assessment were interviewed by nurse and social work clinicians. The researchers concluded that accurate information could be gathered and appropriate service packages established via telephone (McGrew & Quinn, 1995). In the Hamilton County program, Basic and most Ongoing clients receive assessments via telephone. Well over half of these clients receive only one program service, and 87% receive two or fewer services from the county home care program. This innovative approach to case management allows for lower intensity assessment and monitoring when appropriate, which helps to control program costs, yet maintains program quality.

Data on timeliness from the earlier evaluation showed that on average, the time elapsed from the assessment to the start of services was about 10 days for the Case Management group (who always received an in-home assessment and formalized care plan), and two to three days for Basic and Ongoing clients, for whom services could be ordered following the telephone assessment. The multilevel case management system allows for those who do not require the higher intensity intervention to receive services shortly after the need has been established.

Future Innovations in Home Care Delivery

The local levy funding allows these agencies to structure the case management and community services differently from the traditional system. Although the trilevel system has been the major innovation in care delivery, the projects are currently exploring additional practice innovations. One such change is an effort to involve consumers much more extensively in the planning and monitoring of in-home care received. The use of multilevel case management recognizes that varying types of care are needed; however, the approach continues to assume that some type of case management is necessary for all service recipients. In the consumer-directed model now being implemented in Franklin County, there is an assumption that some older people or their families are able to be more involved in directing their own long-term care despite the presence of chronic disability.

Another case management and service alternative tested in the Franklin County program is the clustered services approach. The model organizes service delivery so that a team of home care workers is assigned to a cluster of clients who live in close proximity, typically an apartment complex. The structure makes it possible for the home care worker to provide personal care and homemaking in time blocks that meet the daily living needs of the client rather than the scheduling needs of the home care agency. This clustered services concept has been combined with a clustered care management model in the Columbus area. Care managers are housed in the clustered buildings, rather than in the central offices. They perform the same traditional care management function of assessment, care plan development, service coordination, and monitoring the quality of care. However, their mode of practice is considerably different. Case managers are able to have considerably more contact with clients. Many clients are seen informally on a daily basis and almost the entire caseload can be seen throughout the week. The clustered case management model also allows for a greater deal of interaction between case managers and home care workers. This ongoing dialogue between case manager and home care worker is rare in traditional case management structures.

Both the consumer-directed and clustered care models require additional evaluative study. However, preliminary indications suggest that these innovations have potential for improving the efficiency and quality of in-home care.

Discussion

As practice patterns develop there is increased pressure to standardize the approach to delivering care. Efforts to achieve such a goal are laudable; however, there is always a practice tension between creating an intervention that is standard and creating an intervention that continually improves its practice. This article describes an effort to alter the current model of care in an attempt to improve both care quality and efficiency. Each of the variations have, and will continue to, spark debate within the practice community.

Although there have been over 20 research demonstrations designed to evaluate the effectiveness of
case managed in-home care, few of these studies examined care management practice. Questions about the optimum level or approach to delivering case management have not been addressed. What is the best way to organize in-home care? Is it reasonable to rely on a telephone assessment to order services, or is such a practice in direct opposition to the principles of case management? With a large number of case-managed clients receiving one or two services, is case management being oversold as a care concept? These are the types of questions that need to be examined as we expand in-home services.

Debates surrounding these and other practice questions will certainly continue. The ultimate practice wisdom of any new intervention is certainly unclear. However, what is clear is that the long-term care arena will continue to change, and that with these changes will come the challenge to test, and possibly alter, traditional case management practice.

References


