ABSTRACT

CASE MANAGEMENT
IN INTEGRATED MODELS OF CARE

By Susan K. McGeehan

The purpose of this study was to better understand case management in integrated models of care. Semi-structured interviews were completed with state and program level administrators and case managers from nursing and social work disciplines to ascertain their perspectives about case management. The professionals interviewed, who represented eight programs across the United States, discussed the benefits and difficulties associated with providing case management to a population with a wide range of needs. Respondents also discussed important issues related to interfacing with different health care professionals, and raised questions about the overall purpose of the case manager role. The findings suggest a need to unify the purpose of case management in integrated care programs. Findings also indicate that educational and training efforts for case managers require closer consideration and that there is a need for future research to focus on the value of social services in a medical model of care.
CASE MANAGEMENT
IN INTEGRATED MODELS OF CARE

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Dedication

I am dedicating this thesis to my mother, Mary McGeehan, who is responsible for my return to school earlier in my life than I, more than likely, would have pursued on my own accord. She has pushed me when I have not wanted to be pushed and believed in me when I did not believe in myself. Her positive attitude has always been there to pick me up at my lowest points and has given me the strength to move forward throughout graduate school and life in general.

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Chapter One

Introduction

The United States is a wealthy nation, yet our approach to health care has been criticized for lacking a systems focus. Even with the advancement of public awareness surrounding illness and the societal expectation of government responsibility for the care of older persons, the United States remains the *only* industrialized nation that has no system of guaranteed health care for its citizens (Weitz, 2004). The current approach to health care will be further strained in the future by the aging of the baby boomers. The health care system is problematic for older people for two reasons: 1.) Home and community-based services to meet the needs of older people with chronic illness has been slow to evolve, and 2.) Efforts to meet the needs of acute and chronic care clients within our service delivery system have been limited (Leutz, Greenberg, Abrahams et al, 1985). As the aging population increases, so too does the need for a continuum of care to address the complex acute and long-term care needs that are inevitable and already overwhelming our present system.

To address the challenges associated with trying to merge acute and long-term service systems, a range of programs and demonstrations designed to integrate these two care systems has been implemented. Despite the fact that a number of integrated models of care have been attempted and some are still in existence, there is not a clear cut way to categorize or operationalize this approach (Davis, 2001). Leutz explains that integration “…can signify anything from the closer coordination of clinical care for individuals to the formation of managed care organizations (MCOs) that either own or contract for a wide range of medical and social support services” (Leutz, 1990, p.77).

Integration occurs at the clinical and managerial levels. Additional integration occurs at the funding level, which often times is a major component of the success, or lack thereof, for integrated models of care. It is clearly understood that to achieve service integration, integration of funding streams must occur, be it from consumers directly, insurance providers, Medicaid and/or Medicare. Some approaches pool funds from all of these areas, while others pool some combination of sources. Programs of an integrated nature typically use a capitation system where a fixed dollar amount is provided to the care coordination unit. It is widely known that older people account for a disproportionate amount of Medicaid spending and that
national and state governments have been trying to curb health care expenditures since their inception.

A review of expenditure growth for these two programs shows large increases in these programs over the last two decades. For Medicaid, the per capita expenditures more than doubled for the elderly, blind and individuals with disabilities from 1978 to 1998 (CMS, 2005a). The National Association of the State Budget Officers reported that in 2000, “over nineteen percent of total state spending and over forty-two percent of federal funds provided to states were spent on Medicaid” (CMS, 2005b). In 1980, Medicare spending was $37 billion and had reached $290 billion by 2004. During this time the eligible Medicare population did increase, but in a disproportionately lower rate compared to the increase in budgetary expenditures (CMS, 2005a). Many integrated models of care attend to the needs and funding opportunities available to the dually eligible population- seniors that meet eligibility for both Medicaid and Medicare. It is evident that both of these programs would benefit from changes and creative efforts to improve cost effectiveness.

To adequately meet the needs of the dually eligible population, a comprehensive arrangement of long-term care and acute service must be available. This is partially due to the fact that dual eligibles “may often be confronted by problems of access, a lack of continuity of care, limited administrative coordination between Medicare and Medicaid, an institutional bias affecting service, and confusion with coverage and payment” (Clark & Hulbert, p.4, 1998). Despite the fact that this portion of our population would greatly benefit from coordinated approaches to service provision, they are faced with confusing and fragmented selections of services, differing from state to state, and city to city. The difficulties dual eligibles face while attempting to receive care is further exacerbated by the dichotomous nature that Medicare and Medicaid offer within their funding structure, service delivery and coverage. These are many of the problems that integrated models of care have to overcome for the dually eligible population.

Beyond the benefits to the dually eligible population, integration has many other benefits, but there are still disincentives and impediments to the growth of integrated care models. The structures of Medicare and Medicaid serve as barriers to integrated care models, as do laws and regulations regarding care. Other disincentives include: payment systems, information systems, culture, and staff education and training. There are both micro and macro
disincentives and benefits to consider when looking at integrated models of care. One of these is the role of case management/ integrated team coordination approach.

Case management is extremely important as beneficiaries often need a professional to navigate the complexity of these systems and to advocate on their behalf. An integration of care approach coupled with integrated funding strategies seems like an efficient and potentially cost-effective approach to remedy many of the problems our current health care system faces.

The benefits of the case manager/integrated team in an integrated care model cover a range of outcomes. Identified benefits include; cost containment and improved access to services needed (both medical and social), improved consumer satisfaction, increased efficiencies across long-term care components, and improved consistency, quality and reliability across professional disciplines. Policy makers and administrators may feel as though the role of case management has little impact on the success or budgetary status of the program, but in fact, this role has much impact. For these reasons, it is important to study the role of case management in integrated models of care.

Because of the multi-layered significance of the case manager role, it is important to have a clear understanding of how case management works. Because case managers working within integrated models of care must interface differently with other professionals, and be able to provide both acute and long-term care needs often times to a more diverse client base, it is even more significant to understand the current practice of case managers in integrated models of care.

The perception of case managers within a program from the state level program administrator to the direct service level of the case manager is relevant when trying to determine what does, and does not work. Although state level program administrators do not routinely interact with the case managers, they are the individuals making the policies and changes to practices, so their impressions of this role are very significant. Of additional significance are the impressions of case managers and local program administrators related to case management in integrated models of care. All three perspectives offer different insights and have the ability to affect change within the integrated models of care and the role of case management in different mediums. For these reasons, it is very important to understand how the role of case management impacts integrated models of care.
This paper reports on a qualitative study regarding the role of case management in integrated models of care. Case management is seen as an important part of the integrated care solution. Yet we need to learn much more about the case management approach. What is the optimal way to provide case management? What is the role of case management in integrated models of care? This work will address these important questions. First, the study will present additional background about the current system.

The Birth of Health Care Insurance

Understanding how our current system of health care developed is relevant when trying to understanding today’s problems of service and program fragmentation. The integrated models of care currently in use attempt to fit within, often unsuccessfully, current policy, fiscal and political lenses. Difficulties with these innovative approaches to care make the success of these programs and the role of the case management difficult. Below is a review of health care history as it relates to integrated models of care.

It was during the great depression in the 1930’s that health insurance companies were first conceived. Blue Cross was created by the American Hospital Association to help Americans afford their hospital bills. Many felt that the government should be responsible for those citizens who could not afford their own health care, but there was no governmental program or policy in place. In response, the hospitals were the first to develop health insurance in the United States (Rothman, 1997). The purpose of Blue Cross was to protect hospitals from financial risk and shortly thereafter, the American Medical Association offered Blue Shield insurance to safeguard doctors from financial risk. Both Blue Cross and Blue Shield were set up as retrospective reimbursement systems, paying individuals for their health care related cost after an episode of illness, and also paying the providers for each covered service provided (Weitz, 2004). It was through these programs that pressure for government sponsored insurance was temporarily relieved. Following Blue Cross and Blue Shield, the United States saw a new approach to care with the birth of health maintenance organizations (HMOs) in the 1930’s and 1940’s (Weitz, 2004). “Kaiser Permanente and Group Health Cooperative of Puget Sound were organized by individuals whose primary aim was providing affordable, high-quality health care to their communities” (Weitz, 2004, p.226). HMOs changed the insurance dynamic by offering a system of prospective reimbursement that encouraged doctors to keep their patients healthy. In a prospective reimbursement payment system HMOs were paying for
preventative measures, which was a pro-active shift in insurance and health care philosophy. HMOs remain an important component of health care and have been instrumental in the development of integrated models of care, although fee for service has continued to be the dominant model for insurance coverage.

Other insurance companies formed after the initial HMOs and Blue Cross / Blue Shield. The success and prominence of these insurance policies among the middle class ultimately resulted in a skewed focus of governmental responsibility related to health care with the result being a reduction in political pressure to pursue a government sponsored health care system among the proportion of the country most likely to vote (Rothman, 1997). Given the haphazard development of health care in the United States, it is not surprising that our country struggles with such fragmentation and that case management has been proposed as a solution for this problem.

The Beginning of Government Health Care and a System of Entitlement

The notion of a national health insurance system was discussed in the early twentieth century. Theodore Roosevelt endorsed a system of national health insurance during his 1912 presidential campaign. President Franklin D. Roosevelt and his successor, Harry Truman, were also enthusiastic about implementing a national insurance program to cover all Americans. Neither of these efforts were successful however, due to concerns that national health insurance was a “form of creeping socialism” (Weitz, p.228, 2004; Congressional Quarterly, 1980). By 1960, health insurance coverage for elders in America was a very hot topic, as health services were not financially attainable for many. After considerable debate in 1965, Title XVIII (Medicare statute) and Title XIX (Medicaid statute) of the Social Security Act were enacted, expanding health insurance coverage to select portions of the nation (Weitz, 2004; Jackson et. al, 2000). With private insurers already in place, this two-pronged governmental approach contributed to the development of a fragmented system of health care that would become difficult to navigate, and highly inefficient.

Medicaid and Medicare were written such that eligible citizens were entitled to the benefit. Although Medicare was conceived as social insurance and Medicaid as a welfare benefit, the programs developed in unexpected ways. At the time Medicaid and Medicare were passed, the life expectancy for men was 65. In 2001, the average life expectancy for a man was 74 and for a woman was 79 (Jackson, 2000; SSA, 2005). Increased life expectancy brings
with it increased budgetary pressures, which was problematic since these government programs were essentially created with no spending caps.

Medicare was set up to cover acute care needs of people aged 65 and older. Medicare was to ensure that an affordable health insurance system was in place for those who were eligible for Social Security benefits or railroad retirement benefits. Most Social Security beneficiaries are automatically covered by part A of Medicare, which provides hospital coverage (excluding doctor services while hospitalized), skilled institutional care and medically needed home health care for a limited time following hospital discharge. Part B of Medicare was structured as an optional “supplementary insurance plan” that would cover other outpatient services and the cost for doctor services that were not covered in Part A (Congressional Quarterly, p.77, 1980).

Medicaid was set up to meet the acute and long-term health needs of the indigent, regardless of age. This program is jointly funded by the federal government and the states. Depending on the state’s per capita income, the federal share ranged from 50 to 78 percent of total program expenditures. A congressional Quarterly report in 1980 stated “Medicaid compliments Medicare by providing about four million persons aged 65 and over with benefits. While Medicare has benefited one in every nine Americans, Medicaid has reached one of every five Americans” (p.80).

The government had anticipated sufficient health care coverage for older people through Medicare and private supplemental insurance. For those older people who did not have adequate coverage, Medicaid was there to fill in the gaps. Unexpectedly, Medicaid became the major source of long-term care benefits for individuals with disability. In fact, the original legislation did not include the intermediate care facility benefit, which provides the majority of nursing home coverage today.

The systems in many ways seemed to be complimentary with Medicare addressing primarily acute care needs and Medicaid long-term care needs. Even with this synergy, true integration still has not occurred due to the incremental nature and inertia of these systems. The funding structures differ as well as the bodies regulating the services, which results in much fragmentation, access confusion, and a need for coordination between systems.
Our Recent Past: Scrutiny of Health Care Funding

As programs and services boomed, concerns about the cost for the new programs and services surfaced. In response to fragmentation and rising expenditures, The Allied Services Act was introduced to Congress in 1972. This act was to coordinate social service agencies utilizing case management to improve access to services (federal, state and local) and to assist individuals in overcoming difficulties associated with bureaucratic requirements. However, the Act did not pass (Quinn, 1993).

It was in 1972 under section 222 of the Medicare Act that an initial set of demonstration projects was authorized for experimentation with community-based services, physician and hospital reimbursement, and home care and day health programs. Many of the new initiatives utilized case management as a new service (Quinn, 1993). In 1973 President Nixon signed the Health Maintenance Organization Act, which “put federal support in back of HMO growth, through subsidies for launching new ones and other provisions that would help to expand enrollment in all other existing HMOs” (Roemer, p.103, 1982). Without the federal support of HMOs, the first integrated models of care may have happened much later, and may have had a different face altogether.

The Medicare capitation demonstrations (with seven HMO sites participating) started in 1980, with some referring to 1980-1985 as an “Experimentation Phase” for Medicare (Rossiter, p.49, 2001). The passage of the Omnibus Budget Reconciliation Act (OBRA), in 1980, resulted in a 300% increase in the number of for-profit home health care agencies between 1982 and 1984, and a forward direction for community-based services under Medicare (Quinn, 1993). The forward motion of community-based services, along with the change in the political atmosphere allowing for demonstration projects, opened up new opportunities for changes in health care that would attempt to remedy some of our country’s most serious problems.

With the passage of OBRA 1981, community-based services for eligible populations under Medicaid were encouraged. The states were given flexibility to experiment with waivers to traditional Medicaid requirements directed towards reduction of costs to Medicaid. Many of the states focused their efforts on reducing expenses incurred by care for older people. However, the changes made to Medicaid through OBRA 1981 now allowed for a public program to pay for case management services through one funding source that would be able to provide a number of both health and personal services (Quinn, 1993). With flexibility to
formulate waiver programs to meet the needs of eligible citizens, many states increased their efforts to assess elders more closely to avoid costly institutionalization. Additionally, “the new programs had the ability to integrate health and social services for clients of all ages, and, in effect, were capable of handling persons with chronic care needs” (Quinn, p.20, 1993). This was the political change that allowed the door to open for integrated models of care.

The Tax Equity and Fiscal Responsibility Act (TEFRA) was enacted in 1982 and was designed to provide “innovative and creative programs that offered efficiency and effectiveness by providing care across the continuum” (Genrich & Neatherlin, p.14, 2001). With these intentions, provision of case management became an excellent option and the concept of providing care across the continuum a seemingly efficient idea.

In 1984 the Deficit Reduction Act passed, which provided the opportunity for the first model of integrated care to occur- Social Health Maintenance Organizations (S/HMO). The S/HMOs were designed to provide typical HMO packaged services in addition to social health services, therefore meeting the needs of acute and chronically ill members. The services were to be coordinated by case managers and funded by integrating Medicare, Medicaid, private insurance and client cost-sharing. With this approach to funding, the S/HMOs “avoided the regulatory and reimbursement constraints of the current [1985] system” (Quinn, p.22, 1993). On the state program development front, over 100 waivers, from more than 40 states had received approval from the Health Care Financing Administration by 1986. Of these programs, 85% utilized case management since it was now a reimbursable service (Applebaum & Austin, 1990). With increased flexibility of the Medicaid waiver services in the states, government support of S/HMOs, and attempts being made to minimize Medicare funding, a future of integrated models of care was in the making.

**Models of Integrated Care**

In 1972, passage of section 222 of the Medicare Act authorized demonstration projects for experimentation with community-based services as a way to test different options that might be cost efficient. For the same reasons, with the passage of OBRA 1981, states were encouraged to try new strategies for community-based services for eligible populations under the Medicaid waivers. The passage of section 222 and OBRA 1981 changed the aging network, and laid the foundation for integrated models of care. The end result of these two pieces of legislation was encouragement to try various approaches to integration, which played
a major role in how case management evolved into the much needed service in health care that it is today. With these changes, it is not surprising that state agencies have been restructured in the hopes of better coordinating responsibilities, that home and community-based services have increased while limiting the supply of institutional care, and have made efforts towards single-entry-point systems of service allocation (Coleman, 1996, as cited in Mollica, 2003).

Although the first large scale integrated model of care started in 1985 with the S/HMO demonstrations, many other approaches have been tried and are still underway today. The various approaches to integration incorporate these themes in different ways and are described below.

Social Health Maintenance Organizations (S/HMOs)

The prominence of HMOs in the health care system provided the foundation for the S/HMOs concept. With the increased popularity of HMOs and managed care systems, health care administrators were forced to focus on “the complex needs of individuals with acute and chronic health conditions and to the challenge that functional and cognitive limitations, multiple funding sources, and multiple service providers pose to the traditional health and long-term care systems” (Mollica & Gillespie, p.8, 2003). With the dual benefits that HMOs provided to consumers and payers, it is not surprising that an extension of the HMO approach to health care was utilized as one attempt to provide integrated care.

With the advent of Medicare demonstration funding through the Health Care Financing Administration, S/HMOs found their place on the United States health care map. The demonstrations took place in four sites, Portland, Oregon, (Medicare Plus II), Minneapolis-St. Paul, Minnesota (Senior Plus), Brooklyn, New York (Elderplan), and Long Beach, California (SCAN Health Plan) (Harrington, Newcomer, 1990; Davis, 2001). The rationale underlying S/HMOs is that meeting the social service needs of enrollees will result in improved medical care (Newcomer, Harrington & Kane, 2002).

As previously stated, the S/HMO model was based on the success of previous HMO models, but additionally incorporated long-term care benefits not typically offered in HMOs. Services such as homemaking, respite care, custodial nursing home care, eyeglasses, outpatient prescription drugs, hearing aids and non-emergency transportation were added to the traditional HMO services, which were hospice, durable medical equipment, skilled nursing, home health, and hospital and physician coverage, amongst others (Newcomer et al, 1994; Leutz et. al, 1985;
Davis, 2001). The S/HMOs offered services that would meet the needs of a population with acute and long-term care needs. The basic HMO provisions of the S/HMO are financed through prepaid capitated payments from Medicare, which are based on the enrollee’s age, sex and level of care (Newcomer et al, 1994).

The outcomes of the first generation S/HMOs were not as favorable as some had anticipated. All the demonstrations reported losses the first three years, though some reported positive balances during their first year of financial risk (Health Care Financing Administration, 1996; Harrington and Newcomer, 1990 as cited in Dowd, 1999). Disenrollment rates revealed findings that were somewhat unexpected, as enrollees with acute and chronic illness were more likely to disenroll than the healthy enrollees (Newcomer et al, 1994).

Despite the less than positive outcomes of the first generation S/HMOs, OBRA 1991 called for second generation S/HMOs to be established. Only one site however, was actually implemented (Davis, 1999; CMS, 2005).

Program for the All-inclusive Care for the Elderly

In 1985, the On Lok integrated model of care, referred to as The Program for the All-inclusive Care for the Elderly (PACE) was approved by CMS as the first non-S/HMO integrated model of care in the United States. OBRA 1986 mandated 10 demonstration PACE sites based on the original On Lok model. The On Lok model took twelve years to develop, and other replication sites took anywhere from two to four years to implement. Since 1990 the National PACE Association has recruited other sites for participation and continues to educate states about this option for integration.

The structure of the PACE site requires that participants switch from their primary physician to the PACE Medical Director. Additionally, participants are required to attend the adult day health center on a regular basis, although some sites are experimenting with waiving this requirement. These two requirements make recruitment difficult for providers (Branch, Coulam & Zimmerman, 1995; Gross, Temkin-Greener, Kunitz & Mukamel, 2004). Enrollees are assessed by members of an interdisciplinary team at the health center and have the opportunity to meet with a wide variety of health care practitioners in one locale. In addition to receipt of services at the day health center, enrollees are also eligible for services in their
homes, such as rehabilitative services, homemaker, personal care, home delivered meals, social work, attendant care, and skilled care (Eleazer, p.210, 1996).

When a PACE site is in its mature phase (at the point where the site assumes full financial responsibility), integration of acute and long term care occurs, with an interdisciplinary team providing case management. The interdisciplinary team consists of “representatives from medicine, nursing, pharmacy, nutrition, transportation, social work, home care and recreational therapy.” Additional services addressing dental, hearing, vision, podiatry, psychiatry and internal medicine needs may be provided on a contractual basis. (Eleazer, p.210, 1996).

Through Medicare and Medicaid waivers granted to PACE provider organizations, this model of care is able to meet a wide range of needs, from prevention to rehabilitation, to acute care up through long-term care in the community (Eleazer & Fretwell, 1999). Because the PACE sites assume financial responsibility and are unable to shift costs, the model attempts to “manage financial risks by keeping participants as healthy as possible through preventative health practices and frequent monitoring of their status” (Kunz, 1996, as cited in Eleazer & Fretwell, p. 105, 1999).

Community-Based Case Management and the Dually Eligible Population

There have been multiple forms of integrated care that have been tried and/or are currently operating. All the initiatives tried have required some sort of change in long-term care policy. Robert Mollica, from the National Academy of State Health Policy explains that “Driven by demographic trends, consumer preferences, and the importance of addressing functional and health needs in a more comprehensive manner, state governments have undertaken multiple initiatives to reorganize delivery systems serving older people with functional limitations and chronic conditions” (2003, p.165). The approaches different states have taken vary and may be related to a decrease in nursing home reliance, increased facilitation between medical and social services, increase in consumer options and direction, improved access to needed services by means of care management, or to assure and/or improve quality of services (Mollica, 2003).

There is much need to focus on the dually eligible population considering that in 2002, 14% of all Medicaid enrollees were dual eligibles. During that time, the annual Medicaid expenditure for long-term care for the dual eligible population was 65% of all Medicaid long-
term care expenditures, and 4% of the budget for other acute care users (The Kaiser Commission on Medicaid and the Uninsured, 2004). CMS data showed that dual eligibles represent 16% of the Medicare population and are responsible for 30% of Medicare expenditures (Mollica, 2003). The portion of our population aged 80 and older most likely to become dually eligible due to impairments and general frailty is expected to increase 100% for males and 50% for females by the year 2025 (Clark & Hulbert, 1998). Mollica also found “Of dually eligible beneficiaries, 30% have no regular source of care, and 33.4% use emergency rooms when care is needed versus 20% and 18% respectively of Medicare-only beneficiaries” (p.174, 2003). These daunting figures raise concerns for the way in which our health care system should be structured to meet the pressing dual eligible needs, particularly given the high cost of health care in the U.S.

One approach to integration for the dually eligible population is to pool Medicaid and Medicare funding and then select a managed care organization (MCO) to integrate services and funding as appropriate. With this approach, a MCO would have fewer constraints on service provision and funding and would also be able to utilize the array of resources from Medicare and Medicaid more creatively (Kane, Homyak, Bershadsky et. al, 2003). There are numerous disincentives to doing this, such as obtaining CMS approval for integrated models of care, the intricate nature of developing new programs, and difficulties associated with securing health plans to provide and manage services for beneficiaries. Despite these disincentives, there were 24 states in 1997 that had enrolled Medicaid beneficiaries into managed care plans (Mollica, 2003).

The various states that have programs to meet the needs of dual eligibles structure case management differently. However, each program must try to deal with the differing regulation requirements of both Medicare and Medicaid, and in some cases, work within the constraints of the managed care organization’s regulations as well.

Case Management

The success of integrated models of care relies heavily on case management. Given the need to coordinate the social and the medical professions and to maximize the funding streams, it is impossible to imagine a model surviving without effective case management. A study of four states, completed in 1997, found that:
- Dually eligible beneficiaries are more likely to require coordination and case management services than Medicare only beneficiaries because they have a greater incidence of acute and chronic conditions.
- Care coordination staff who created links with the long-term care system were reported to improve care for dually eligible beneficiaries who are more likely to use a range of medical and non-medical services.
- Coordination is more difficult when beneficiaries receive care from different systems.
- Because of the complexity of coordinating services for multiple providers and payers, consumers should be partners in the process (Mollica & Gillespie, p.9, 2003)

Despite the movement in the health care system towards integration of care, the system currently in place remains an amalgam of our past service structures and has failed to progress with the changing needs of our aging population, making the role of case management a necessity in most programs for the aged.

**What is Case Management?**

Because of the changing nature of the United States health care system, the role of case management has continually evolved, making a consistent definition of case management difficult. Some assert that case management has conflicting goals, making case management rather ambiguous. Carol Austin explains that “Case managers are expected to simultaneously control expenditures and improve quality, to view the client as a customer but to limit choice, to efficiently manage unmanageable workloads, and to provide client-centered services” (p.179, 2002). Most experts agree that case management can be described in relation to central tasks, such as “outreach, screening, assessments, care planning, planning implementation, monitoring and reassessment, however, considerable variation remains in how case managed care is actually delivered in different program contexts, serving diverse target populations” (Austin, p.178, 2002). To merely focus on the individual tasks that compromise case management does not do the profession justice. There is much more involved when you consider the context in which case management is performed, which is why research about the role of case management in integrated models of care is so important.

**What do Case Managers do?**

The role of a case manager varies depending on the fiscal constraints he or she must work within, as well as the structure of the program. The fiscal constraints ultimately dictate the amount and variety of services case managers can allot while the structure of the program determines the actual case manager process. *What* the case manager does differs from what the
case manager is at liberty to do- with the necessary focus being on the client’s needs. The remainder of this paper will focus on case management in integrated models of care. However, it should be noted that some types of case management strictly apply to a medical model, others a social model. Most case management roles within integrated models present themselves as a combination of the two. Some interdisciplinary teams leave more of the social needs to the “case manager” role, while others function in a truly “integrated team” fashion, with all participating entities unified in their actions to meet the needs of the client.

Case Management Components as related to Integrated Models of Care

The central case management functions are: access/linkage/outreach, coordination, communication, gatekeeping, service management, monitoring, quality assurance, education and assessment. At any given time, these responsibilities may overlap, depending on the structure of the case manager position in a program. For instance, to manage or coordinate services with providers and clients a case manager must be an effective communicator. Linkage and outreach are closely tied to education and are effected by the ability of the case manager to communicate complex systems or processes. These central components mixed together are how case managers accomplish their jobs.

One of the most important components of case management is providing access/linkage/outreach to their clients. Case manager activity in this area is designed to help reduce fragmentation and ensure more consistent, high-quality, and cost-effective care. Coordination is particularly important for a case manager in an integrated model of care, where they will need to link activities in both the medical and social services areas. Communication is essential for linking social and medical systems together to meet a common goal, regardless of the case management approach. Gatekeeping is often viewed as a negative piece of care management, but is emphasized in many care management positions in general. “Gatekeeping mechanisms are designed to control the number and types of services that clients receive, particularly high cost services…” (Applebaum & Austin, p.39, 1990). The case manager as a service manager allots services as needed, and develops a care plan based on professional assessment(s). Service management is structured differently in integrated models of care with some case managers not doing the medical care planning independently, but working cooperatively with specialized medical case managers. Case managers must monitor clients for
ongoing eligibility and regulatory conformity, which may be more complicated in integrated models of care and differing funding systems.

The case manager is a “go-to” person when quality issues arise. The case manager will explain what is and is not acceptable as far as service provision goes. This can be more difficult when integrating care because the various regulations set by funding bodies must be adhered to. Case managers must educate their clients about their illness, and prevention, when appropriate. Many of the integrated models of care have prevention built into their program, often times resulting in a payment structure that includes incentives for preventative care.

Assessment is an important aspect of every case manager’s job.

Approaches to Case Management

Some integrated models of care have individual case managers, and other programs utilize an interdisciplinary team/multidisciplinary team. There does not appear to be any consensus in the literature about which approach is better, though recent history has shown an increase in the team approach to case management.

Interdisciplinary Team Approach to Case Management. One recent development in integrated health care programs is the growth of the interdisciplinary team. Some programs refer to their team as a multidisciplinary team (making use of several disciplines at once), while others are referred to as interdisciplinary teams (involving two or more distinct disciplines); the term “interdisciplinary team” will generically be used for both throughout this section.

Interdisciplinary teams may be as small as a nurse and social worker and may be large enough to include speech, occupational, or physical therapists, mental health professionals, dieticians, home health aides and transportation providers. The group of professionals work as a team, which in most cases, means there is not one set “case manager.” Some teams meet together to manage cases, other teams circulate care plans with each professional completing their portion. Some programs use a mix of these case management approaches. Some interdisciplinary teams will have a designated person on the team to be the main contact and manager, but all of the professionals will still provide input to the case as appropriate.

An interdisciplinary approach to care emerged from the On Lok model. Some professionals feel strongly about the need for interdisciplinary teams now that our health care systems have become increasingly fragmented, even in programs that do not address the needs of elders with both acute and chronic care needs. Some programs have used teams specifically
for care planning, while others have used a team approach for assessment purposes only (Applebaum & Austin, 1990). However, for a team approach to work, each team member must be clear about what his/her role is and be flexible to accommodate and respect the opinions of other professionals on the team. There must be consensus about the group’s values and norms, and the group must hold a common commitment to the purpose and mission of the team. An interdisciplinary team must function with the cohesiveness of a shared purpose, with all team members recognizing one another as equals and with a spirit of interdependence rather than autonomy. Finally, there must be flexibility with leadership and decision making which is enhanced by open communication and sharing (Cowles, 2000).

The underlying rationale for case management via an interdisciplinary team is that only through a continuum of health care skills and knowledge, jointly contributing to the coordination of care, can maximum effectiveness and efficiency be obtained. By meeting the needs of the client, with both long-term care and medical services, there will be a reduction in service gaps and overlaps ultimately resulting in cost efficiency and service effectiveness. Other benefits to a team approach to case management include a wider perspective to help identify the client’s needs, the benefit of having professional peer support and shared responsibility and commitment to decisions made (Grisham and White (1982) as cited in Applebaum & Austin, 1990).

The Individual Case Manager Approach. Historically, case management has been done on an individual basis. From the conception of Medicare and Medicaid and state initiatives, fragmentation of services has always been a concern. One of the benefits of an individual case manager approach is cost; if additional input is needed, this can be provided in the form of purposive assessments or consultation. Some experts suggest that group decision making in the development of care plans is not always cost effective (Applebaum & Austin, 1990).

Additional problems of interdisciplinary team functioning are:

- Turf protection,
- Different values and perceptions of the problems and needs,
- Self-promotion,
- Prestige and status discrepancies that impair open communication,
- Lack of understanding of one another’s language, skills, and knowledge areas, and,
- Differences in the problem-solving process (Julia and Thompson, 1994, as cited in Cowles, p.20, 2000).
In particular, the participation of a client’s doctor as part of the interdisciplinary team has been noted as a recurrent problem with a team approach to case management. An example of this was noted in the On Lok demonstration which resulted in the structural change of having participants change their primary physician to the On Lok physician as a way to overcome the difficulty of doctor participation in a team approach to case management.

Additional arguments have been circulating in the case management arena about whether a nursing or social work background is better suited for case management. With the nature of integrated models of care, it is difficult to ascertain which would be better. In 2001, a study supported by the J.A. Hartford Foundation used focus groups with home health social workers and nurses to identify barriers and understand current roles in home health care. The findings from this study found three types of barriers for social workers and nurses in home care - informational, systems and interprofessional, as summarized below:

**Informational Barriers:** “The focus group revealed home health care nurses’ lack of understanding of social work roles. Home health nurses and social workers have different perceptions of the actual functions of social workers, leading to differences in identifying patients who need social work services…”

**System Barriers:** “1.)…Medicare takes a medical model orientation to home health benefits, which make the psychosocial aspects of care secondary service [resulting in turf battles]. 2.)…Organizationally, the high per diem percentage of social workers creates communication barriers in managing patient needs between the case manager-the nurse- and the social worker.”

**Interprofessional Barriers:** “Due to the differences in their education and orientation, the approaches to patient treatment differ between social workers, who use a psychosocial and patient empowerment model, and nurses, who use a medical treatment model. This can create interprofessional conflicts…” (Lee & Gutheil, p.104-105, 2003).

While some may argue that a nursing background is superior to that of a social worker for the duties of a case manager, others attest that neither are adequately qualified due to a lack of educational programs that specifically teach case management skills. It is unclear what type of professional is better prepared to be a case manager and to meet the wide variety of needs when trying to coordinate services for elders in integrated models of care. The best approach and structure for integrated models of case management is also unknown, be it a team approach, an independent case manager approach, or a combination. However, most integrated models of care have both nurses and social workers and may have them formally or informally available to assist the other profession as needed when managing a case. The concerns of cost efficiency and service effectiveness have a prominent role when trying to decipher what will work best.
The fact remains that “Case management programs are context responsive and operate as interventions at several levels simultaneously. The result is that no two case management programs are the same” (Summers, p.90, 2000).

Summary

Integrated models of care are a beneficial approach to managing the acute and long-term health care needs of the older population with disability. There are lessons to be learned from the experiences of the current models regarding the approach and structure to case management as well as identification of issues that are currently emerging and will need to be addressed as the aging society changes.

To be able to understand the significance of the case manager role in integrated models of care, one must first understand integrated models of care. A historical perspective of the United States health care system and the policies that allowed for integrated models of care has been presented. With the state of our service delivery system, the need for coordination of services and improved access for consumers is critical. A brief synopsis of some general approaches to integration has been laid out in this chapter to provide a clearer understanding about the multi-leveled needs for case management across health care professionals, service providers and macro-level health care systems. The general roles of case management have been explored as have approaches to case management and barriers to integrated models of care. Based on this foundation, the research will investigate the impressions and opinions about how case management in current integrated models of care.

The research conducted in this study is done with state level administrators, local program level administrators and case managers to better understand the role of case managers in integrated models of care. All three levels are critical when assessing the significance of case management. All three groups impact the future of integrated models of care. Case management is an individual service, but the benefits of effective case management have large scale implications that state and federal program administrators must recognize. To improve the current system of services, we need to focus on what has worked and how, which is why understanding the role of case management in integrated models of care is the purpose of this research. In response, the study will address issues surround the following overarching research questions: 1) who should do case management, 2) how is case management in integrated care
systems done, 3) why is case management important, and 4) what barriers do case managers in integrated models of care currently face.

**Chapter Two: Methodology**

**Program Selection**

A review of programs designed to integrate acute and long-term care and interviews with key informants in the field were utilized to identify a list of states that have pursued integrated models of care. The key informants were identified by reviewing the existing literature and through a snow-ball sampling of experts. After these interviews were conducted and a further review of the literature completed, a list of potential states and basic information describing them was assembled. Program descriptors included: funding source, eligibility criteria, number of clients served, care approach, and program status. Based on this work, eight programs were selected for the in-depth study (See Table 1).

Final selection criteria included: the program served more than 100 clients; the program is not primarily a housing program (offering integrated care incidentally); and the program highlights integrated care as a unique aspect of its mission. Programs selected were designed to provide services to meet the needs of older people with acute and chronic illness. Some programs included in this study did require an intermediate level of care, as defined by Medicaid eligibility for nursing home services.

As shown in Table 1, the selected sites for this research ranged from a county-based program to a state-wide effort, with as few as 590 clients, to as many as 63,000 clients served in the year 2004. Integrated models of care provided case management by either an individual case manager, or a multidisciplinary/interdisciplinary team approach. The integrated models of care were operated by various entities, such as insurance providers, government entities, or general health care providers on a contractual basis. The funding structures for each of the programs studied differed. Some had strict funding eligibility requirements; others integrated funding from a variety of sources, such as Medicare, Medicaid, private insurance and private payment. All programs were funded through capitated systems. A brief description of the eight sites selected follows.
Table 1

Selected Characteristics of Programs Participating in Study

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>Clients Served '04</th>
<th>Eligibility Criteria</th>
<th>Catchment Area</th>
<th>CM Approach</th>
<th>How Services are Provided</th>
<th>Year of origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas: Star+Plus</td>
<td>&gt; 63,000</td>
<td>Most aged adults not institutionalized are required to join</td>
<td>Harris County</td>
<td>Individual</td>
<td>Evercare &amp; Amerigroup HMO providers</td>
<td>Designed 1996; mandatory in 1998</td>
</tr>
<tr>
<td>Minnesota: MSHO₁</td>
<td>7,144</td>
<td>65+, Mcaid eligible, reside in county program is offered in</td>
<td>10 counties</td>
<td>Individual</td>
<td>Metropolitan Health Plan, Ucare Minnesota, and Medica</td>
<td>1997</td>
</tr>
<tr>
<td>Wisconsin: WPP₂</td>
<td>2,087</td>
<td>Must be Mcaid eligible, ILOC, and reside in zip codes in which program is offered</td>
<td>4 sites in 6 counties</td>
<td>Team</td>
<td>Not For Profit organizations</td>
<td>1995</td>
</tr>
<tr>
<td>Massachusetts: SCO₃</td>
<td>11,065 (as of 4/05)</td>
<td>65+, Mcaid eligible</td>
<td>95% of the state</td>
<td>Team</td>
<td>2 Not For Profit and 1 For Profit organization</td>
<td>March 2004</td>
</tr>
<tr>
<td>Ohio: Senior-Link₄</td>
<td>590</td>
<td>55+, Mcaid, ILOC seniors, residing in the community</td>
<td>Specified zip codes in 5 counties</td>
<td>Team</td>
<td>Tri-Health &amp; Concordia Care provide</td>
<td>1996</td>
</tr>
<tr>
<td>Oregon: Senior Advantage II</td>
<td>1,300 using expanded care</td>
<td>65+, Mcare A&amp;B living in the community in specific geographic catchment area</td>
<td>All counties in Portland area plus 5 others</td>
<td>Individual</td>
<td>Kaiser Permanente Northwest Division</td>
<td>1984</td>
</tr>
<tr>
<td>California: SCAN</td>
<td>&gt; 20,000</td>
<td>65+, Mcare A&amp;B living in the community in specific geographic catchment area</td>
<td>zip codes in L.A., San Bernardino, Riverside and Orange counties</td>
<td>Individual</td>
<td>HMO providers</td>
<td>1984</td>
</tr>
<tr>
<td>Arizona: ALTCS₅</td>
<td>25,513</td>
<td>65+, Mcaid and ILOC</td>
<td>Statewide</td>
<td>Individual</td>
<td>For Profit and Not For Profit HMO providers</td>
<td>1989</td>
</tr>
</tbody>
</table>

1.) Minnesota Senior Health Options 2.) Wisconsin Partnership Program 3.) Senior Care Options 4.) Senior Link is A PACE site (Program for all-inclusive care for the elderly) 5.) Arizona Long Term Care System
Arizona: Arizona Long Term Care System (ALTCS)

ALTCS is a statewide program providing subsidized acute and long-term care services to elders, people with developmental disabilities and younger adults with physical disabilities. ALTCS is part of Arizona’s Medicaid program and provides care management to enrollees in the community, nursing homes and assisted living facilities. ALTCS provides both Medicaid and Medicare services as the program integrates these funding sources through capitated managed care. Arizona contracts with both for-profit and not-for-profit HMO providers throughout the state for ALTCS service delivery. In addition to basic care management, the delivery of services is structured through specialized care models, such as the medically complex team or behavioral health team. Once enrolled in ALTCS, services are ongoing. There are no educational requirements for case managers, although having two years experience is a prerequisite for the position.

California: SCAN

SCAN is an original Social Health Maintenance Organization (S/HMO) from the 1985 federal demonstration. SCAN is a not-for-profit organization providing coverage to community-based and institutionalized people age 65 and older residing in Los Angeles, San Bernardino, Riverside and Orange counties. SCAN is a health plan offering comprehensive medical benefits and home based long term care services through the Independent Living Power benefit. SCAN participants are referred to the Independent Living Power Personal Care Planner for long term care benefits if determined to be eligible during an assessment or after a change in health status. The Independent Living Power Personal Care Planner will manage only the social long-term care benefits and they refer out to a RN case manager to meet the client’s medical needs. Independent Living Power services are provided on an episodic basis. SCAN prefers to hire social workers with Master’s degrees but will hire BSW or related degree individuals for the Independent Living Power Personal Care Planner position. SCAN will be phasing out the Independent Living Power benefit in the future but will remain active as an insurance plan.

Massachusetts: Senior Care Options (SCO)

SCO was implemented in March, 2004 and coordinates care through a primary care team, which consists of a physician, nurse and social worker. Program participants are required
to change their primary care physician to a physician within the SCO network. SCO provides services to low income elders residing in the community or in a long term care facility. Both Medicaid and Medicare services are provided to SCO clients as the program integrates these funding sources through capitation. Three different organizations (two not-for-profit, one for-profit) have been contracted to deliver SCO services. Each of these organizations provides services in their own way following general financial and clinical SCO guidelines as mandated by Massachusetts. Each provider approaches case management differently, with one provider being more of a physician based model, another a nurse based model and the third a more traditional team approach. All providers are required to have a social worker from an Area Agency on Aging working collectively as part of their team. Social and medical services are ongoing for program participants.

Minnesota: Minnesota Senior Health Options (MSHO)

MSHO provides primary, acute and long term care services to Medicaid beneficiaries aged 65 and older in ten different Minnesota counties. Minnesota contracts with three not-for-profit organizations, which create delivery networks of their own through subcontracts. Contract providers in MSHO provide both Medicaid and Medicare services with the program integrating these funding sources through capitation. Services are managed by a care coordinator for enrollees who may reside in the community or nursing home setting, with the care coordinator following the enrollee across the spectrum of care. MSHO hires social workers and nurses for the care coordinator position. Minnesota hopes to make MSHO statewide in the future.

Ohio: Senior Link

Senior Link is an official PACE site, providing services to elders aged 55+ meeting the intermediate level of care in specific zip codes within five counties in Ohio. Senior Link is managed by TriHealth, which is an organization formed from the merging of two Cincinnati acute care hospital systems. Senior Link provides both acute and long-term care services through capitated payment of Medicaid and Medicare in addition to private pay clients. Clients must be community based to enroll in Senior Link but Senior Link will remain the payer for all care across the continuum once enrolled. Senior Link has the traditional PACE model where clients are required to attend the Day Health Center to be eligible for the program and also has a pilot program where the multidisciplinary team is community based and the clients do not
need to come into the Day Health Center. Care coordination is done through a multidisciplinary team approach with the following professionals on the team: primary care physicians; social workers; nurses; home care staff; physical, occupational and recreation therapists; van drivers, a day health center supervisor, transportation coordinator, home care coordinator and a dietitian. Senior Link hires Masters level social workers and registered nurses for their team member positions. Senior Link has one main location currently, but is in the process of building a second Day Health Center in the Cincinnati area.

Oregon- Senior Advantage II

Senior Advantage is one of the original Social Health Maintenance Organization (S/HMO) from the 1985 federal demonstration and is managed by the Northwest division of Kaiser Permanente. Senior Advantage is in the Portland Metropolitan area plus five other Northwest areas and functions through capitated payment systems. The expanded care benefit is the long-term care component of the S/HMO and packages community-based long-term care benefits with an expanded array of primary and acute care services optional for elders aged 65 and older that meet nursing home level of care. Resource coordinators provide case management of the expanded care benefits on an episodic basis. Enrollees are required to pay 20% of the benefit expense up to a maximum of $12,000 per calendar year. Resource coordinators are required to have a degree in social work, nursing or have a background in a related field.

Texas: Star + Plus

Star + Plus integrates acute and long-term care services and is mandatory for most community-based aged and disabled adults in Harris county (also provides services to children and other eligible age groups). Texas contracts with Amerigroup and Evercare HMO providers to provide the services and allows the provider to decide how they want to structure their case management. Clients first speak with an “enrollment broker” who is able to explain the services and assist the client in selecting a provider (enrollment broker is through a separate administrative contract than providers). A care coordinator in the HMO will then provide ongoing services, funded through capitated Medicaid and Medicare payments. Some clients are placed in a disease management program with more intensive care coordination to assure they get the care needed for that disease. Texas originally required the HMOs to hire RNs or MSWs, but no longer requires the contracted HMOs to hire those specific degreed disciplines,
leaving the decision up to the providers. Star + Plus hopes to expand into seven other metropolitan counties in the near future.

Wisconsin: Wisconsin Partnership Program (WPP)

WPP is a program that integrates health and long term care services for people with physical disabilities and elders who are Medicaid eligible and meet the criteria for intermediate level of care. WPP contracts with four not-for-profit organizations to provide care coordination in six different counties in Wisconsin through capitated payments. Care coordination is ongoing and done through a multidisciplinary team consisting of a social worker, nurse and geriatric nurse practitioner that is assigned to specific doctor’s offices, acting as a liaison for the doctor to the team. WPP is sometimes referred to as a “PACE without walls” program as the structure is similar with three main differences: participants may retain their doctor if he/she is part of the program or agrees to join, there is no requirement to attend an adult day center, and the team caring for the client is typically smaller (though other disciplines/expertise are called in as needed). WPP requires RNs and social workers for their team members. WPP hopes to expand further into Wisconsin in the future.

The programs selected offer a variety of approaches to case management and have different eligibility criteria. Once the programs were selected for participation in the study, the next step was to secure the informants, which will be explained in further detail below.

Informants

Because of the complexity of integrated models of care it was important to know the impressions of state officials, local administrators and direct service workers concerning case management in integrated models. Case managers work within the framework of an organization and thus the role of case management is affected by the local and state level administrators. Summers, a health program evaluator who has examined several case management programs states that “Organizational issues are particularly relevant in evaluating case management” and need to be “considered within the evaluation” (2000, p.89). For these reasons it is important that the state and local program administrators be interviewed as well as the case managers about the role of case management within integrated models of care.

Because state level program administrators make decisions about resource allocation, comparing their views to staff with implementation responsibilities seemed quite important. The program administrator perspective was also critical since they provide management and
monitoring and have to provide justification and validation for the case management services on a regular basis. Finally, the case managers are the workers who provide a hands-on view of the mechanics of the integrated model of care, and it is this group who has the best feel for how the program is working for consumers. Because the perspective of a nurse and social worker are so different and all programs studied hired both disciplines for the case manager position, a case manager from each discipline was interviewed in each program.

It was anticipated that there would be much variation between the three levels of respondents. One challenge was to formulate precise questions to be able to view the role of case management in the most complete and comprehensive manner. The nature of this research is a process and role evaluation, not an outcome evaluation.

A total of 32 interviews were conducted for this study. The first set of respondents was selected based on the state level position they held. Because the state level program administrator was able to provide access and information, they were interviewed first. The state level administrator was asked to suggest the name of a local level program administrator to be interviewed, and then the local level administrator was asked to give the names of two case managers (a social worker and nurse). Because each state structure differs, as do the integrated models of care, no requirements were set or negotiated when requesting the name of the individual to be interviewed.

Data Collection and Analysis

Communication with the state level program administrator was made via phone or e-mail to schedule the telephone interview. At the start of the phone interview, but prior to asking the actual interview questions, a brief explanation of the purpose of the interview was given and any questions posed by the respondent answered. The people interviewed were told that their responses were being typed into a document by the interviewer as they spoke, but the interviews were not audibly recorded. Four different sets of semi-structured questions were created to guide the interviews. There were six questions to the state and local level program administrator, and ten questions asked to the individual case manager and to the case manager representative for a team approach (Appendix A-D). These questions were broad in scope, designed to cover specific areas, but to also allow respondents to focus on areas that they thought were important.
After the larger questions about individual perspectives related to case management were posed, probing questions were pursued, as needed, to obtain the desired information. Respondents were questioned about how they described case management in their program including barriers, pros and cons, how case managers interface with other health professionals, skills needed for case management, changes that could be made to facilitate better case management, and questions about case managers’ backgrounds, training and education.

As each interview was completed, responses were placed into tables that streamlined the concepts and impressions related to case management. After all interviews were completed, a more intense analysis of the initial tables was completed, resulting in the findings reported here.

**Limitations of the Research**

There are some limitations to this research project that should be acknowledged. The relationships that the state level administrators have with the programs and their contracted providers all differ, which may result in different opinions about the role of case management. For instance, some states allow more freedom with the contracted agency to structure their approach to case management than others, which may in turn affect their opinions about the way case management is done. State level administrators gave referrals for program level administrators to be interviewed and in many cases had to choose between multiple organizations that implement the program in and/or throughout the state. The providers in some programs had very different approaches to case management so the findings in these interviews are really only representative of the particular organization interviewed.

There was no experience criterion used in selecting the case managers to be interviewed. Variation in the way case management is structured can also affect the responses given by the case managers, such as differences between individual case manager responses as compared to interdisciplinary team case management. Both nursing and social work disciplines were interviewed within each program, but other professionals are hired for the case manager position as well and would possibly have differing perspectives about their position that will not be recognized in this study.

Another limitation of the study is related to the findings. The findings in many cases group both individual case managers feedback with the feedback of case managers on an interdisciplinary team. Similarly, the findings of the program and state level administrators
from both individual and team approach to case management are often times grouped together. Where the findings between the two approaches were significant, this differentiation was made when presenting the findings. For the findings that this difference was not made, some of the variance may be related more to the structural difference in the approach to case management.

**Chapter Three: Research Findings**

**Introduction**

In this chapter, the themes that emerged from the interviews conducted with the state level program administrators, local program level administrators, and local program case managers will be presented. These findings describe the role of case management in varying integrated models of care. The first section is about who should do case management (CM), encompassing issues such as education, previous experience, significance of discipline, and the most important skills needed. The second section examines how CM is working in the integrated models of care. The third section explores opinions about why CM is important, CM status, what other roles are needed, and how CM within the integrated models of care compares to other CM approaches in the state. The chapter will conclude with a review of CM barriers faced in integrated models of care and the difficulties identified in care planning, allocation of services for a diverse population, and in working with other health care professionals. When discussing service recipients, the generic term “client” will be used although different programs use different terminology for this role.

**Who should do Case Management?**

Questions about the appropriate or ideal level of education and discipline for case managers have been common in the literature (Genrich, S.J. and Neatherlin, J.S., 2001; Lee, J.S. & Gutheil, I.A., 2003). There is, however, no consensus in research or practice about the answers. Some social workers interviewed in this study expressed concern about a diminished need for their discipline in the future, because they believed that some programs were moving away from a social services model towards more of a medical model. Findings of this study suggest that the effectiveness and need for different types of CMs have more to do with CM role than their education or disciplinary background.
Both state administrators and program administrators were asked if they had a disciplinary preference for the CM position. The most frequent response (7 out of 16) was that both social workers and nurses are needed in their program. Some administrators responded that both skill sets are needed: “At some point or another the diverse client base they work with will require both sets of skills.” And that both are needed to “bounce stuff off of one another.” When discussing the structure of CMs in programs with both the nurse and social work CMs their responses were very much in line with these statements, and most reported a very open relationship in which approaching the other discipline for input was very common.

One fourth of the administrators did state their preference for a CM with a nursing background because “it is easier to educate a nurse about social work practices than it is to educate a social worker about medical practices.” Another factor was that it is easier to find nurses with social services experience than social workers with health care experience. Lastly, because nurses have an easier time making contact with doctors than social workers they were more attractive as CMs to some administrators. Another one-fourth of the respondents reported that the role of a CM should not be limited to only social workers and nurses. Administrators reported that there may be a place for therapists, or that their program currently will hire people for the CM role that have related backgrounds such as sociology, psychology or ample previous experience working with the aged. Only one administrator expressed preference for a social worker stating that social workers are better rounded, are able to separate the human element from the medical need and “are better trained to pick up on clues.”

The program administrator and the CMs were all asked if they felt success in the CM position was more about education or experience. The majority (14 out of 24) responded experience was most important. Program administrators remarked that the new graduates without any experience have a hard time when hired because the position has so much autonomy. They also stated that although education is important, “there still needs to be a balance between business and care,” and that the “people without the exposure to the elderly take the longest to get oriented.” Social work CMs who stated experience was most important reported that “it is not my degree that makes me a good CM, it is my attitude, training and experience,” and that you need experience “because it is unlike anything else you will learn in school.” One nurse CM remarked “clients care how you communicate with them, not what degree you have.”
None of the program administrators felt education was most important; five of the CMs reported education as most important. One social work CM stated “education is important; there are basic skills and fundamental knowledge that people should have when working with this population.” Another social work CM stated, “education gives someone a good perspective on health care and settings, which is really important.” One nurse CM stated “you have to have the education to understand the training to get the right experience,” and another reported “higher education is necessary, with a background of gerontology or community services.” Six of the interviewees were unable to select either education or experience, stating both were equally important. Many interviewees stated that personality has as much to do with success as education or experience.

CMs were asked to rate eight different components of CM into one of three categories: very central to their job, somewhat central to their job and not very central to their job. Because of educational backgrounds, it was anticipated that clear differences between the disciplines would be found, such as social workers rating access and linkage as more of a priority than nurses, or that education of clients would be more important to nurses since RNs traditionally have been in more of a medical education role in home care. The anticipated differences were not found. This may mean that the nurses and social workers in a CM role prioritized their job based on the position more than their respective disciplines. The findings are presented in Table 2 below:

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Access/Linkage</th>
<th>Coordination</th>
<th>Communication</th>
<th>Gate Keeping</th>
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<tbody>
<tr>
<td></td>
<td>very</td>
<td>some</td>
<td>not</td>
<td>very</td>
</tr>
<tr>
<td>CMSW</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>CMRN</td>
<td>8</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Service Management</th>
<th>Monitoring</th>
<th>Quality Assurance</th>
<th>Educating Clients</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>very</td>
<td>some</td>
<td>not</td>
<td>very</td>
</tr>
<tr>
<td>CMSW</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>CMRN</td>
<td>4</td>
<td>4</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

Table 2 also shows that communication and coordination were consistently rated as central to CMs regardless of discipline. Although likely that communication and coordination
are important to CMs in all settings, it may even be more important in integrated models of care where CMs work with more professionals and have to coordinate care for a wider range of needs.

Program administrators were asked what makes for an effective CM. The responses fell into three general categories: personality, job functions and skills. Program administrators felt the top personality traits were passion, drive, positive attitude, being aware of your own strengths and weaknesses, creativity, and a true desire to “help the needy.” Effective CMs had the ability to be flexible, a good awareness of community resources and the health care system, embraced the organization’s mission, and had the ability to be timely in follow-up and documentation. Necessary skills identified by the program administrators were: understanding of the aging population, an ability to negotiate, well-organized, good clinical background, overall competency, and awareness of cultural, medical and social needs clients may exhibit.

CMs were also asked about the skills they felt were most important for the success of someone in their role. The skill mentioned most by both disciplines was communication. CMs talked about communication between peers and clients, and the need to be able to understand how others communicate, as well as being able to actively listen. The second top scoring skill identified by social work CMs was patience, which included discussions around coping mechanisms, perseverance, and the ability to compromise for the good of the client. Assessment and problem solving skills were tied for the second top rated skills reported by nurse CMs. Discussions around assessment were about being able to prioritize, being non-judgmental, background experience and medical and psychology knowledge. Skills such as investigative techniques, education, and negotiating came up when talking about problem solving.

Based on the responses across all three levels it does appear that the CM role in integrated models of care needs to include a mix of professions. Some CMs in programs that do not systematically unite social work and nursing identified this as an area to work on, or stated they would forge those close relationships on their own accord because it is so important to the job they were doing. There does seem to be some consistency in the belief that it is easier to train nurses on social services than it is to train social workers on the medical side. However, several administrators discussed the difficulties in finding nurses to do the CM job,
so they have had to be diligent in their training endeavors for the social workers to allow for sufficient medical training.

**How Case Management is done**

Each integrated model of care structures the CM piece differently based on their approach to CM, regulations and guidelines imposed by funding bodies, services allowed to be authorized, and structure/design of CM position. Based on the interviews with program administrators and CMs three cross-cutting themes were identified:

1. What is and is not working well?  
2. What is most important and difficult for the CMs?  
3. What structural or design changes could be made to help the CMs do their jobs better?  

When asked what the most important aspect of the CM job was, program administrators responded most often about skills. Some of these skills were listening, being able to recognize what others value, knowing how to assess and what is most important to pull out of assessments, being timely, flexible, and have the ability to multi-task. Also mentioned were personality traits, such as compassion, a desire to work with the aged, having a holistic view, and being able to develop trusting relationships.

Program administrators were also asked what they felt was the most difficult part of the CM job. Time management, establishing boundaries, documentation requirements, many guidelines to adhere to and the cyclical nature of the position, which “can get boring” were identified. Some difficulties that were more relevant to integrated models of care included: working with medical staff, having to defend your opinion to other disciplines, and gaining access to primary care physicians (PCP) and various health systems. Some program administrators spoke about service provision and management issues as the most difficult part of the CM position. Identified in this area was a need for more service providers in the system, and in general, a need for improved transportation for clients.

CMs were asked about additional services their employers could offer to help them do their jobs better. CMs reported a need to improve dental benefits and to increase the number of psychology and mental health services/networks they could work with. Social work CMs spoke more about financial matters and transportation problems, suggesting financial planners, and special funds to help clients with co-payments. Nurses were more inclined to talk about medical services, such as weight loss programs, podiatry benefits, “new age medicine,” durable
medical equipment and an increased number of hospital networks. The additional services identified by CMs appeared to be complementary to their disciplines.

When asked to describe how the CMs did their jobs, CMs were also asked to talk about the things that work best and those that did not work. Social work CMs spoke about the amount of face-to-face contact and having one “point person to navigate the system” as the top ranking pieces working best in their programs. Nurses spoke more about program structure issues, such as peer and supervisor support. Other pieces identified by the CMs as working best were the use of improved technology for record-keeping and communicating with providers, being able to pay family members to provide care and being bilingual. CMs in programs that function through interdisciplinary teams reported the “group approach,” or “all the disciplines working together,” and the “blending of mental health issues and physical health issues that occurs in a team” as what worked best in their program. Interdisciplinary team members also talked about the benefit of having different disciplines together to talk about a case, recognizing that the final recommendation for the care plan ends up being very different than it would be had an individual made the care plan. Many CMs spoke about the benefit of increased flexibility related to the integration of Medicare, Medicaid and their own network services to provide a broader service package and to not be limited by Medicare guidelines.

When asked about what does not work the best, many typical CM issues were mentioned, such as lacking quality/consistency of providers, issues around accountability with home care workers, safety concerns in different neighborhoods, and caseload sizes. Social work CMs discussed problems with the amount of data collection they must do beyond their required assessments, financial limitations of the program, low referrals due to community being unfamiliar with the program, and that “we are made as incompetent as the state” due to state guidelines passed onto program CMs. Nurses spoke about the shortage of skilled RNs, the shortage of general caregivers, and the way caseloads are determined based on medical complexity as some of the pieces of their job that do not work best. The CMs working on interdisciplinary teams reported difficulties with the time required for a team to make a decision, problems with involving outside consultants, and the lack of efficiency due to all team members having a chance to give input on a client. Some general difficulties identified were related to the need for lap-tops to decrease duplicative work, problems with dental and psychology benefits/providers and problems associated with using interpreters.
Both program administrators and CMs were asked to think about structural or program changes that could be made to the position to help the CMs improve their performance. Program administrators typically suggested decreasing the documentation requirements, lowering caseload sizes, lessening the communication restraints HIPAA imposes upon CMs, increased funding to hire more people and improved technology. Some of the suggestions that were not as commonplace were to have CMs housed in a different physical location that would not have as many in-house regulations, to have the model become more education oriented, and to focus more on disease management.

Many of the CM suggestions were similarly predictable, such as removing duplicative and overlapping work, decreasing caseload sizes, decreasing “irrelevant data collection,” increasing face-to-face contact with clients, better client/CM consistency, and improving technology. CMs indicated the need for more information, or better sharing of community resources. Other suggestions, such as increased flexibility with funding, better support from upper management, a “better balance between state mandated assessments and care,” and more “formal integration of social workers and nurses” were made. Some of the team members on the interdisciplinary teams spoke about restructuring the teams and changes that could be made in their approach that would help them to process cases more quickly.

Program administrators also identified structural components that have contributed to the success of their program. Some of these pieces included: having “field-based coordinators” to decrease travel time to and from the office, having a mix of professional disciplines to “bounce ideas off of,” flexibility within the model to allow more members to be served, and structuring the “delivery through specialized care models.” Some pieces that work best for the interdisciplinary team approaches are looking at a client from all different disciplinary perspectives, pulling together the medical and social management, and not having a set “team leader for each team, but letting it vary by each client’s issues and which team member knew the client the best.”

Many of the themes that emerged from the interviews about what does and does not work best in integrated models of care are applicable to most CM positions. Although communication is important to all CMs, it might be even more important to CMs in integrated models of care that are trying to meet both acute and long term care needs, while working with multiple professionals from various disciplines. Some CMs spoke about how they had to learn
to communicate with other professionals to be effective in their position. Most of the interviewees agreed that working with professionals from different disciplines, formally or informally, was best because it allowed the CMs to meet a larger range of needs just by having someone nearby to ask questions if needed. Most of the interviewees from interdisciplinary teams felt very strongly about their approach being a key to their success, though issues of efficiency were noted as one drawback to this approach. CMs stated that mental health issues have been steadily increasing and the need to improve the benefits to meet clients’ needs will require more attention in the near future. All interviewees agree that the integrated models of care are successful only with a set person (CM) to assist the clients in navigation of the health care system. This is true of all CM positions, but particularly crucial in the integrated models of care.

Why Care Management is Important

Respondents universally agreed that the CM piece is integral to the success of their integrated model of care. Interviewees were asked if there were other roles that were responsible for the success of the program as well. Five out of 32 people interviewed felt there were other roles that should receive credit for the success of the program along with the CM piece. Some state level administrators responded that “each role in the integrated models of care is important,” or that “the other systems supporting the CMs are important to their job,” and that “all people in contact with the client can make or break the program for them.” One state administrator reported, “having entities willing to be at full financial risk when integrating Medicare and Medicaid” was just as important to the success of the program as the role of CM was. Only one program administrator felt other roles were integral to the success of the model stating the administrative staff plays an important role. Despite these other roles identified, all agreed that the CM role was central to the program’s success.

Administrators were asked why they felt CM was so important. The majority of responses to this question addressed the importance of improving access to services for the consumers. Both sets of administrators spoke about the benefit of having a CM “to follow you across the continuum of care.” Some state administrators used phrases such as “glue of the integrated model of care,” “point person,” and “vital to the complex systems we have to work in.” Program administrators reported that CMs were “system navigators” and a “broker to community resources.”
Some structural issues were noted as well. State administrators reported that CM was important because “CMs help improve the system by offering insight into design work,” that in general the “design of the CM role is important,” and that “the CM role is seen as a service, not administration.” Program administrators reported that CMs were “the backbone of the company,” that they “carry out the mission of the organization” and are the “cornerstone of our program.” Other areas of importance were the CMs ability to “mitigate risk,” to provide the “mechanism by which the program can accomplish integration at the consumer level,” to “look at medical and functional needs,” and to be “the ones on the front line advocating for the clients.” The responses of those administrators in programs that used interdisciplinary teams were somewhat similar to programs that have CM done individually. State administrators stated CM was important because: it “allows for care to be provided across services and sites;” that CM allowed for “better outcomes in a cost effective manner;” that “there needs to be integration and coordination in order for all the components to work;” and that CM is important because “everyone involved has a say-so in the case.” Administrators from programs that used interdisciplinary teams reported that “the beauty with this approach is that you know when things will go astray,” that the team “interfaced with everything” and that with the team approach “they use a true geriatric holistic approach.”

The CM role includes system responsibilities such as gate keeping, managing cost and utilization of services, mitigating risk, and clinical management of the client’s needs and services. Interviewees were asked if they felt the CM role in their program was focused more heavily on system or clinical responsibilities. While it has been reported that the CM role is integral to the success of the programs, a critical question raised is what aspects actually contribute to the success of CM? It was anticipated that the administrators and CMs would have varying perspectives on this question.

There were only two programs that from top to bottom that agreed on the underlying purpose for CM. Comparing the responses of social work and nurse CMs in the same program, there were only two programs in which the CMs agreed upon the purpose of the CM position. Also noted was that of the 12 interdisciplinary team interviewees, ten felt the CM focus was about clinical outcomes. Not much other consistency was noted, which is significant in and of itself. The general findings from the question about the purpose of the CM role are presented below in Table 3.
### Table 3 Perception of role of Case Management

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1.) State Level Administrators, 2.) Program Level Administrators

It is interesting to note the lack of consistency regarding the purpose of the CM role in these integrated models of care. The interdisciplinary team members seem to have more agreement than staff in the other models. The findings may suggest that individual opinion regarding this issue may be more about the role than the individual’s discipline.

State administrators were asked how they felt the CMs in the integrated models of care compared to CMs in other state programs. Only one respondent felt more positive about other state CMs, stating “Other state CM models force people to ‘the true calling of CM’ to pretend like you have nothing to give but your ability to assess & meet the needs.” All other feedback was positive about the CMs in the integrated models of care. Other state administrators reported that “Other CMs in state are about eligibility referral- but our CMs are about the individual,” or that “They generally have more power than typical CMs. They have a broad range of authority to authorize services, which does not always happen in other programs” and that “They are common in their home visits and goals, but differ in their ability to problem solve within systems. Our program CMs are better prepared.”

The social work CMs felt they compared very positively to other CMs in the state. Some reported that “We are looked at as being revolutionary” and that “I think our program was an anomaly-it took a while to understand, people felt threatened.” The responses from the nurse CMs were mixed regarding how they compared. This difference seems to be related to more of a comparison within discipline and the fact that the RNs working in the CM role do not have as high of a demand for skilled services and do not interact with other nurses and doctors as frequently. Some nurse CMs responses were “They [other state CMs] probably see us as a convenience instead of a necessity. We don’t interact as much with RNs in the medical side of things either” and, that “This job is mentally harder than other home care CM jobs. Clients used to look at us like we were practically MDs in home care.”
Because CMs in integrated models of care may have a higher incidence of working with doctors and other medical providers as well as working within different payment structures than Medicaid alone, state administrators and CMs were asked if they felt there was a different status for the CMs in their integrated model of care. Only one state administrator felt negatively about the status of the CMs in the integrated model of care, stating that “They still are the secondary status.” The remaining state administrators felt their CMs had higher status; remarking that “they have high esteem and are respected,” that “Our CMs have more status than other CMs in state” and that “LSWs in traditional waiver programs-their status with doctors was less than zilch.” One state administrator stated that “there are so few outcome studies that demonstrate the value of CM” and continued to talk about how the value and status of all CMs would change if there were better tools in place to measure the effectiveness of CM outside of decreased hospitalizations, emergency room visits and doctor appointments.

Of the state administrators interviewed from the interdisciplinary team programs, the feedback was very positive about the status of their team members. Some remarked; “Doctors afford our team members more regard than the traditional CMs; that “the team says they are almost an extension of the MD” and that “Our team would seem to have close to equal status of other programs with a team approach.”

The findings between the nurses and social worker CMs were significantly different. All but one of the social work CMs interviewed felt their status was better as a CM in an integrated model of care. The one negative remark was “others view us as the bad guys because we work for an insurance company.” Other social work CMs remarked that their status was higher because “we are more intensive” and “because the population we work with is so unique.” Of the nurses, only one felt there was a positive change in status remarking that “nobody does it like we do.” The other nurses responded that “my status is worse-people see me as a convenience,” that “I have a lower status from peers, but a high status to my clients as I speak their language” and that “it is a lower skilled-wise status, but a better cognitive status.”

The findings suggest a slight preference for a CM with a medical background, but also indicate that the nurse CMs do not feel their status has improved or that they compare better to other nurse CMs in the state. The states with programs that use the interdisciplinary team approach felt their team member’s status was very good and made clear connections between their status and the way their team members interact and are viewed by doctors.
The findings of this research clearly make a connection between the importance of CMs and their ability to navigate the health care system which results in improved access. This is likely an important piece of all CM positions, but quite possibly more important in integrated models of care, which are trying to bridge social and medical needs, and address acute and chronic illness while integrating funding streams. State administrators value CM because they are the workers on the front line calling the shots and creating the care plans that will ultimately mitigate the financial risk faced by the programs. As one administrator responded, the CM role is how integration is done at the client level, which is key to the success of these integrated models of care.

Barriers Faced by Case Managers

Throughout the interviews different barriers faced by CMs have emerged. Barriers include: working across health care professionals, allocating services for a diverse population, the nature of care planning, and how CMs document and share client related information.

Respondents were asked to speak about the barriers in working with a range of health care professionals. Only two of the state administrators viewed the interface between CMs and other health professionals as a barrier. Another state administrator stated it is the “name of the game, of course it is a barrier. That is the nature of integration.” Another state administrator described the problem in these words:

Doctors run into CMs that make the doctors feel –true or not- that the patient is their client, not the doctor’s patient. They [CMs] set up an antagonism. It only takes a doctor to run into one of those, to peg the whole profession that way. All need to work together to see the value of each other.

One state administrator who felt interfacing was not a barrier explained that it is “clearly the centerpiece to the success because of it being an integrated program.” Three program administrators felt that interfacing with other professionals was indeed a barrier, but necessary in integrated models of care. One program administrator stated that interfacing was “Not a barrier, but a challenge.” Another program administrator recognized that it takes training and a certain type of individual who will be comfortable working across disciplines.

Working across professions is a different issue for programs that do CM through a team approach as the professionals formally work together. Some of the state administrators in those programs remarked, “The concept of a team reduces barriers that could arise. When I hear that everyone is a member of the team it means something different,” and that “the team members
have to communicate and work effectively with other professionals, if not, the clients suffer.”
Some of the feedback from the interdisciplinary team members was that it has been “No
problem, there is not [a barrier] because of the model and because our doctors know the
program- what it is all about,” with another remarking “I haven’t sensed the hierarchy has been
an issue so far- it is more getting access to the primary care physician than the fact they will not
talk to us.”

Most of the social work CMs interviewed did not feel that there was much of a problem
interfacing with other nurses, but did state that communication with doctors can be difficult.
Some responded that “As a social worker I rely on the nurse to tell about medical stuff- we
know each others strengths,” and that “I always feel the nurses are relieved when a social
worker is involved because the social worker will handle the psychosocial problems that nurses
are not comfortable doing.” Some social work CMs had mixed feelings about work across
disciplinary boundaries stating “I feel my peers have a good understanding of what each
disciplines bring to this position, but am unsure all nurses feel we are equals,” and that “I know
that there is a big salary differential between the nurses and social workers and that we are
moving towards a more medical model, but I think my peers and supervisors respect the social
workers.” One social work respondent commented that the “health care hierarchy seems more
prominent in management.” The social workers from the interdisciplinary teams also had
mixed feelings, stating “Sometimes it can be a problem with all the disciplines working
together. Ideally what you will have in sum is different from what each team member does.”

Five nurse CMs reported that there were professional barriers, while one stated there
were not and two felt that it “just depended.” Reasons identified by the nurses as barriers had
to do with working with large county hospitals, being employed by an HMO, other medical
professionals that are not familiar with the program, and working with various medical groups
that have a lot of turnover. One nurse stated that

I am acutely aware of the discomfort that my SW colleagues feel with handling some
of the more direct health condition related issues. I am not as sensitive to that as I
ought to be, so I throw terms around that isn’t [sic] helpful. Also I am aware that I have a
great deal to learn especially in the areas of communicating and linking.

The nurse CMs from the interdisciplinary teams talked about learning how other disciplines
communicate and the benefits of working with the same team members over time. One nurse
commented that,
I don’t think what is required for this type of doctor would be good for all doctors— not all can do this only because they feel their decision is most important and the final decision— not allowing a group of other people to be part of that decision. We can overrule a doctor. I know the social worker and the nurse are like the right and left hand— important for the two to get along.

CMs were asked about their experiences interacting with primary care doctors on behalf of their clients. Some programs require a doctor to be involved, while other programs have a Medical Director on staff that they can work with as needed. The social work CMs reported many more negative opinions about working with doctors than did the nurses. Some social work respondents stated they don’t work with the doctors directly, that they either work with physician assistants, doctor’s nurses or leave messages that usually are not responded to by the doctors. Some social work CMs talked about how it is hard to work with the physician assistants because they are inconsistent and don’t really understand the program. Other social workers spoke about how once you have a good experience with a doctor they will remember and become an advocate for the program. Some respondents also discussed how their Medical Directors would work as a doctor liaison with the community, with one social worker reporting “Our medical director respects our discipline and will call other doctors if we are having difficulties getting their buy-in.” Most social work respondents seemed to have favorable relationships with their Medical Directors, although one social worker did state “I feel not valued when we walk away from meeting with the Medical Director, because we don’t talk about the social piece.”

The feedback from the nurse CMs was generally favorable. They talked about some of the same issues, such as working with nurses in doctor’s offices more frequently, or difficulties associated with working with medical residents, who are not familiar with the program and inconsistent. Some nurses said they would prefer to work directly with the doctors instead of through other nurses. One nurse CM remarked that the doctors are “normally pretty nice to talk to if there is a concern that you are bringing up they are willing to talk to you. The key is to try and talk on their level as best as you can.” Although the feedback was mostly favorable, one nurse remarked that “Medical directors in programs really want to side step direct communication with their program colleagues-ours does this.”

Programs structure the way they do client care planning differently. Some integrated models of care have the social workers and nurses working together formally, others
informally. Most people interviewed agreed that it was best to have both professions represented, as both skill sets are needed in these models of care. However, the way a program structures care planning can be a barrier to the CM job. CMs in the programs that have the two professions working together talked about decreased efficiency, because you need to have the care plan agreed upon by two professionals which takes coordination of schedules and time. Some programs have a structure where the nurses have to look over the social workers’ care plans before they can be implemented, which again may decrease CM efficiencies. Some programs have a completely different department that does the acute care planning which may be a barrier to effectiveness as the care plans risk being disjointed.

Another potential barrier could be the technology used by organizations that are carrying out the integrated models of care. Some CMs spoke very positively about the use of laptops in the field and also being field based to minimize travel time. One CM explained that their program had the technology available to have her office calls forwarded to her home phone and also to send a message on her computer if she was online that she had a call. Some CMs complained about the restrictions they had with using e-mail due to HIPAA, and how this really decreases their efficiency. Not all programs have the same HIPAA rules, with some programs allowing e-mails to providers about clients and others completely restricting e-mails to providers. Some programs have their electronic client records in a fashion that certain providers or doctors have access to the care plans. Some programs do service awards to providers by phone, some use faxes, and others have computer systems in place to expedite this process. The technology used by organizations has a significant impact on the CM job.

CMs were asked to speak about what it was like to allocate services in their program and how they balance acute care and chronic care needs. One social worker responded that “A good CM will be able to prioritize needs and manage both acute and chronic needs. The program guidelines are structured to provide some checks and balances too.” One nurse also spoke about having to be able to prioritize:

It is a matter of establishing the priorities. With those who have acute need- it is acute, and you pay attention… and I think that part of it is knowing that a chronic condition is not impacted in the short term and its been there for a while and you can bring resources to bear.

Some social work respondents spoke about difficulties in not having a clinical background and the time it takes to get input from peers/team members for clinical questions or
for appropriate allocation of services. The CMs working in programs that refer their acute care clients to other departments talked about how this makes allocating services difficult, because of the lack of consistency between departments and services they can offer. These CMs also spoke about how deciding when a condition becomes acute can be difficult as well, especially for those CMs without a clinical background. Some of the nurses spoke about boundary issues because their clients may want more from them knowing they are RNs than what is appropriate for a RN in the CM position. One nurse spoke about education level of the clients having an impact on how services are allocated explaining that “Education levels make it difficult for the chronically ill because follow up is so important, but they have to be able to understand all the ins and outs, the acute aspects.”

Multiple barriers to doing the CM job effectively and efficiently have been explored in this section. Certain barriers, such as interfacing with a variety of health care professionals and the task of allocating services to a population with such a wide range of needs are barriers that are inherent to integrated models of care. Although nurses have been reported to work better with doctors, the findings of this research show that the nurses also reported interfacing barriers. Other barriers, such as the way a program structures care planning and the technology used were also described.

**Summary**

This research is about who should do CM, how CM is done, why CM is important and barriers CMs faced in integrated models of care. Feedback from those interviewed suggests that the way CMs in integrated models of care do their job is more about the CM role than education or discipline. Respondents also discussed the overall importance of personality for success in the CM role. Half of all the administrators, and most of the CMs felt it was important to have both social workers and nurses in the CM position. Communication and coordination were identified as the most important skills for CMs in integrated models of care with experience being cited as more important than education by most CMs.

Social work and nurse CMs had different perspectives about what does and does not work best in their programs and about what additional services they would suggest being added to help them in their CM positions. Administrators identified typical CM issues such as the amount of documentation required, high caseload sizes and budgetary limitations regarding care plans when discussing difficulties associated with the CM position in their integrated
model of care. Social workers had more negative feedback about interfacing barriers than did nurses, though nurses expressed some challenges with this as well.

All but one state administrator felt that the CMs in the integrated models of care compared favorably to other state CMs. Social workers felt their status was increased working in their integrated program, whereas, nurses tended to feel that their status decreased. Almost all state administrators felt that CMs status was higher than that of CMs in other state programs. Every person interviewed for this study agreed that the CM role was central to the success of their program.

There was little consistency across all professionals interviewed when asked if the purpose of the CM role was more about clinical outcomes or affecting the system. In fact, there were only 2 programs that agreed upon the purpose of the CM role across all level of interviews. Of the 12 professionals interviewed from the programs that do CM through a team approach, 10 responded that the purpose of CM was about clinical outcomes. The lack of consistency regarding the purpose of the CM role in integrated models of care is significant in and of itself.

Lastly, barriers such as interfacing with different health care professionals and providers, technology, documentation requirements and allocation of services for a diverse population were identified. Some of the barriers discussed are commonplace to most CMs positions, while others are more unique to integrated models of care. The implications of the findings reviewed in this chapter will be discussed in detail in the following chapter.
Chapter Four: Implications for Practice, Policy and Research

Implications for Practice

Many of the practice issues for case management in integrated models have to do with balance between the social and medical model. Although integrated programs address social and medical needs, the tasks that are more medical in nature appear to be more valued. Typical program outcome measurements tend to be more about medical as well, usually focusing on the number of hospitalizations, emergency room visits, prescription usage and doctor visits. Another example of this is the frequency with which nurse case managers spoke about a decrease in their status because they no longer worked closely with doctors in their case manager role. Interviewees from the interdisciplinary teams spoke about increased status, partially related to the fact that they worked side by side with doctors on a team, or very close and often with doctors.

The findings of this research point out that although these models are integrated, it still seems that the nurses, on interdisciplinary teams and in more independent CM programs, make the majority of care plan decisions. No matter how integrated the program is, the structure of case management does not allow for equality of the professions. Some of the interdisciplinary team models have only the nurse and doctor go out for the initial assessment. In other programs the model uses teams comprised of two social workers and one nurse, with the nurses signing off on all care plans. Some of the independent case manager positions have a structure where the nurses will get the medically complex cases and the social workers receive cases with more social complications. Social workers talked about problems in receiving a transferred client and how it might be uncomfortable if the client previously had a nurse and now had to accept a social worker instead. Meanwhile, the field is having a harder time finding nurses, while programs hint that the future direction of their programs involves moving towards a more medical model. This has major implications for the field and for social work as a profession. If a clinical background, with strong health knowledge, is what state and/or local program administrators prefer, then professionally and academically there needs to be a shift in the focus of training for social workers.

Many respondents talked about how once a case manager has a positive interaction with a doctor, the physician may become a real program advocate and become much more willing to
work with case managers. Some local program administrators talked about outreach efforts they had made to educate doctors about the program and services. The Massachusetts model made the need for physician involvement very clear before allowing doctors to participate in the program. The Kaiser Permanente system makes internal education available for doctors so they can be aware of the benefits they offer. Many case managers spoke about the limited time physicians have to talk over cases. The findings of this research indicate that improved educational efforts for doctors about the benefit and role of case managers would be beneficial.

Where case managers are located seems to have some impact on the effectiveness and efficiency of the job (Leutz, et. al, 1988). Some approaches to case management may be located in an independent environment, others in an academic or research center, while others may be based out of the case manager’s home with no formal office. Some of the case managers interviewed voiced dissatisfaction with the location of their unit. Other case managers were very pleased to be field based and not have to report into an office daily, which improved efficiency. With the increase of the aging population and the inevitable geographic expansion of clients, program administrators are going to have to consider new options to help with case management efficiency and effectiveness.

Lastly, the issue of technology is noteworthy when considering the implications this research has for practice. The days of filling out the assessments by hand and then returning to the office to type in the information are coming to an end. Case managers want laptop computers to take into the field so they do not have to duplicate their written work. Perhaps with this improvement the task of additional data collection will not seem as exhausting to case managers. Some case managers remarked that they would be more effective with laptops as they would be able to better record all of the information their clients tell them on the spot, and would not be as inclined to forget things or overlook pieces of the assessment. It would also be beneficial for programs to communicate with each other about how they are managing to work within HIPAA guidelines. Some programs do not allow any e-mailing of client information while others do. Case managers want to be able to e-mail information; e-mail is the prevalent mode of communication and is ideal for professionals in these types of positions where time management is crucial, but communications need to be made. Investing in computer programs that would assist the case managers in securing providers for services would also help the case managers with efficiency.
Implications for Policy

The most important policy implication for integrated models of care is that every professional interviewed agreed that the success of their program fell on the role of the CM. With that understanding, it is important that issues surrounding the CM position be clarified. There is clearly no consensus about the ideal requirements for the case manager position. Most people interviewed agreed that past experience is very important, but personality and discipline are highly valued as well. Despite the importance of experience, the findings of this research suggest that job satisfaction and status are related to case manager discipline. This was evident by the feedback nurses gave as compared to social workers regarding the questions about their status in their current program and what was more important: education or experience. Some of the integrated models of care have the case manager job prerequisites mandated by the state, while other programs do not have to adhere to state guidelines. From these research findings, no single recommendation can be made for case management requirements, but the unrest this issue provides in the field does have implications for case manager policy in integrated models of care.

Another policy implication relates to case manager skills. If administrators in the integrated models of care identify a need for clinical skills than there needs to be large scale, centralized efforts to provide clinical training to social workers. With the shortage of nurses already a very real concern and the reality that the integrated models of care are moving towards more medical models, the time is now to start preparing the workforce for this need.

The findings of this research support the need for state and local administrators as well as case managers to unify the purpose of the CM position. The fact that there were only two programs where respondents at all levels agreed upon the purpose of case management was an important finding. How is case management performance to be measured if case managers have different expectations for the job than program administrators? How do these differences affect the way case managers allocate services and assess client needs? Lastly, there needs to be a change in the health care environment. Case managers reported problems of interacting with other health care professionals because they were viewed as “the bad guy” working for HMOs. Case managers also reported scrutiny from doctors when the case manager would accompany a client to a doctor’s appointment, again because of the case manager being employed by an insurance provider. There needs to be more education about the benefits of
capitation and services HMOs provide. The lobbying efforts by physicians and hospitals are very strong. All of the integrated models of care function through capitation. “The capitated payment creates an incentive for capitated health plans to identify enrollees needs for assistance with services, preventative care, and the ongoing management of chronic illness” (Malone, Morshita, Paone & Schrader, p.11, 2004). Policy makers need to recognize the full-scale benefits of capitation in integrated models of care, ranging from funding streams to the jobs case managers are doing.

Implications for Research

The most important lesson of this study is the importance of the social services component even in a program dominated by the medical model. One state level administrator pointed out this problem by explaining that, when programs look at outcomes—decreased hospitalizations and emergency room usage; these results give no credit to the social services part of the plan of care. Future research needs to find a way to measure the impact of non-medical services on a client’s medical status. Doing that would have large-scale implications for the place of social workers in integrated models of care in the future, and would also help even out the playing field for all case managers. Doctors would likely be more responsive to case managers if they were able to understand the value of the services they manage for their clients.

More research needs to be conducted on educational discipline, the value of experience and type of personality that works best in the case manager role. With a growing body of literature about this, health care educators and professionals will be better prepared to focus on training topics and the overall need for training. Nurses stated they would prefer having more information about community resources and linkages for their clients and families. Social workers recognized their own shortcomings related to medical terminology and signs of illness. As complimentary as social worker and nurse structures in the integrated models of care are, there still needs to be improved education to make each profession feel more capable in their job.

Finally, there has been much positive feedback about the interdisciplinary team approach to case management in the integrated models of care. Further research needs to be conducted on what team structures are working and why. Different teams require a different
number of professionals and have different regulations regarding who must be present for case conferences. Research needs to compare efficiency and effectiveness of these approaches.

**Conclusion**

Implications for professional practice, public policy direction and future applied research have been discussed. Issues regarding where CMs are housed, equity between disciplines providing CM, training needs for CMs in integrated models of care, the role of physicians regarding CM, and technology were discussed. Professional credentials and amount of experience, the needs for CMs to have clinical training in preparation for workforce demands and a need to unify the purpose of the CM position in integrated models of care were identified as public policy issues. Lastly, there is a need to improve our understanding of training needs in the aging network. Future research needs measurement tools for social service interventions in health-based models and to continue to examine the effectiveness and efficiency of interdisciplinary team approaches in integrated models of care.

There is much to learn from the integrated models of care currently underway and the way in which they implement the case management function. There is no one right answer for how the case manager job should be done, or how a program should structure itself. Some of the state administrators reported the fact that their programs have been able to evolve over time has allowed them to survive political changes and continue to meet the changing needs of the aged population. It has taken a long time to establish a politically viable and supportive environment for integrated care. It is important to continue to expand our understanding of the role of case management in integrated models of care.
References


Appendix A

Individual CM interview questions

1.) I understand your program has case management structured…. I am interested in knowing how you describe case management working in your program- including what works best and what does not…

2.) Rate the following components of CM as:

   - Access/linkage
   - Coordination
   - Communication
   - Gate keeping
   - Service management
   - Monitoring
   - Quality assurance
   - Education of clients

3.) Being an independent case manager, I would imagine the task of allocating services for a population with acute and chronic care needs is very challenging. Can you talk a bit about what this has been like in your position as a CM in an integrated model of care?

   * CM role integral to success?

4.) I remember how difficult it was at times to work with health care professionals from different disciplines. I would think this would particularly be challenging for a program that assists individuals with both chronic and acute needs. Can you talk a bit about this?

   * Background of CM:

   * Does CM do both medical and social care planning?
5.) How often do you interact with doctors, and what is that like?

6.) What skills do you think are most important for someone in your role?

   *educational background most important? Or more about training?

7.) What additional services would help you do your CM job if you had the authority to add some to your current program?

8.) If you could change one thing about your CM job to help you do your job better, what would it be?

9.) Do you feel the CM role is more about clinical outcomes, or more about affecting the system?

10.) Do you feel your status as a CM in your program differs from the status of CMs in other state/local programs?
Appendix B

Team CM Interview Questions

1.) I understand your program does case management from a team approach…. I am interested in knowing how you describe case management working in your program- including what works best and what does not…

2.) Rate the following components of CM as:

   Very central to my job, somewhat central to my job, or not very central to my job

   - Access/linkage
   - Coordination
   - Communication
   - Gate keeping
   - Service management
   - Monitoring
   - Quality assurance
   - Education of clients

3.) Taking a team approach to case management seems to be an increasingly popular way to coordinate care for clients. However, I would imagine the task of allocating services for a population with acute and chronic care needs is still very challenging. Can you talk a bit about what has been difficult in a team approach in an integrated model of care?

   * Team functioning integral to success of the program?

4.) I remember how difficult it was at times to work/interface with health care professionals from different disciplines. I would think at times this might present a challenge on the team. Can you talk a bit about the team dynamics and pros/cons of a interdisciplinary team?
* Background of CM:

* Does CM do both medical and social care planning?

5.) How often do you interact with doctors, and what is that like?

6.) What skills do you think are most important for the success of a interdisciplinary team to function best?

*educational background most important? Or more about training?

7.) What additional services would help you do your CM job if you had the authority to add some to your current program?

8.) If you could change one thing about your team’s approach to case management that would help you do your job better, what would it be?

9.) Do you feel the team approach is more about clinical outcomes, or more about affecting the system?

10.) Do you feel your status as a CM in your program differs from the status of CMs in other state/local programs?
Appendix C
Program Level Administrator Interview Questions

1.) How would you describe the role of case managers in your program?

* What is most important aspect of CM?

* What is most difficult part of CM job?

2.) Is there anything in particular about the structure and design of the CM role that you feel has contributed to the success of your integrated model of care?

* Is CM integral to the success of your program? If not, what role is?

3.) What could be changed regarding the structure and design of the CM role to help the CMs do their jobs better?

4.) When trying to meet both the medical and social needs of a client in an integrated model of care, multiple health care professionals are going to be involved. Do you think the way the CMs must interface with other health care professionals in an integrated model of care is a barrier to doing the CM job effectively and efficiently?

* Do you have an opinion about RN vs LSW?

5.) In your opinion, what makes for an effective CM in an integrated model of care?

* Do you think CM success is more about educational background, or training?

6.) Do you feel the CM role is more about clinical outcomes, or more about affecting the system?
Appendix D
State Level Program Administrator Interview Questions

1.) In your opinion, do you think care management is important? Why?

* What status do you think CMs have in health care?

2.) How do you compare and define CM in your program as compared to CM in your Medicaid waiver program, or other state/local programs?

3.) Do you feel the case management role is integral to the success of your integrated model of care? If not, what role is?

4.) When trying to meet both the medical and social needs of a client in an integrated model of care, multiple health care professionals are going to be involved. Do you think the way the CMs must interface with other health care professionals in an integrated model of care is a barrier to doing the CM job effectively and efficiently?

* Do you have an opinion about RN vs LSW?

5.) Do you feel the status of the CM in your program differs from the status of CMs in other state/local programs?

6.) Do you feel the CM role is more about clinical outcomes, or more about affecting the system?