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Medicare/Medicaid Integration Project

UMCA

Case Management: Methods and Issues

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The Medicare/Medicaid Integration Program

The purpose of The Robert Wood Johnson Foundation (RWJF) Medicare/Medicaid Integration Program (MMIP) is to end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. States are provided with grant support and technical assistance in their efforts to restructure the way in which they finance and deliver acute and long-term care. Technical assistance focuses on those states that have been awarded grants but is not limited to grantees. It is recognized that other states and initiatives can benefit from this help.

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The NCCC has also established a subsidiary corporation, the NCCC National Resource Center on Chronic Care Integration, to provide education, information, and consultation.

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About This Report

This report is one of five technical assistance reports prepared by the National Chronic Care Consortium (NCCC) for the Medicare/Medicaid Integration Program Office. The five reports focus on topics pertinent to creating more integrated delivery networks or coordinated systems of care for people who are dually eligible for Medicare and Medicaid. The topics chosen include:

1. Case Management: Methods and Issues
2. Targeting Beneficiaries Who Are Most at Risk
3. Primary Care for People with Chronic Conditions: Issues and Models
4. Quality Methods and Measures
5. Integrating Information: Selected Issues

The reports draw upon written documents prepared by the NCCC for its healthcare system membership, for healthcare organizations at large, and for organizations participating in the State of Minnesota's dually eligible demonstration, Minnesota Senior Health Options (MSHO). Excerpts from the following NCCC publications/materials appear in this report with permission.

- *Case Management for the Frail Elderly: A Literature Review on Selected Topics,* by Joan Cleary. 1997.

- *Care Coordination Across the Continuum: Examining Approaches to Case Management for the MSHO Client.* 1997.

- *Insights from Beneficiaries: An Examination of the Minnesota Senior Health Options from the Perspective of MSHO Enrollees—A Report from Two Focus Groups Held October 30, 1998.* 1999.

- *Synthesis of Early Learnings: An Examination of the Minnesota Senior Health Options Project from the Health Plans' and Providers' Perspectives—A Report from Three Focus Groups Held October 8 and 9, 1997.* 1998.

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Background and Definitions

Case Management

A primary focus of case management is coordinating services for vulnerable clients—people who would otherwise need to navigate a confusing healthcare system on their own. Some experts have described case management as a service that has arisen because of the fragmented healthcare system.

More than a decade ago James Callahan (1989) critically examined the promise and limitations of case management in a thought-provoking article entitled "Case Management for the Elderly: A Panacea?" He viewed case management as a response to the needs and wants of the healthcare system—rather than those of the older person. While traditional case management offers many benefits, it does not address the fundamental problems of fragmentation that continue to characterize current healthcare delivery for people with chronic illness.

Members of the National Chronic Care Consortium (NCCC) have called for a focus on the broader concept of *integrated care management*. Integrated care management refers to *systemwide* efforts within a healthcare organization to assure that clients receive services that are appropriate to their needs, that are integrated across service settings and over time, and that support client and systemwide goals (NCCC 1995a).

With such a system offering continuity, communication, and mutual support, perhaps case management would not be needed. However, as long as we live with a fragmented delivery system, case management will be one way to bring services to clients according to their needs. Patient benefits may include improved health and functional status, information about and access to needed services across the continuum of care, greater involvement in care decisions, and cost-effective care in the least restrictive setting. Family/caregiver benefits may include the expertise and assistance of an experienced case manager, information and guidance that are helpful to making important care decisions, referral to needed services, and emotional support.

Provider benefits may include coordinating care with other providers, referring patients to other needed services along the continuum, monitoring quality, conserving time through case management of nonmedical needs, and offering input into the exploration of care alternatives. Payer benefits may include patient satisfaction,

Traditional Case Management	Integrated Care Management
Focuses on developing a plan of care with intervention at a specific point in time, e.g. hospital discharge.	**Provides person-centered care** throughout a condition's evolution.
Emphasizes offering care in the least restrictive setting.	**Emphasizes ongoing disability prevention** regardless of setting.
Coordinates services from a variety of unrelated service settings.	**Integrates a full and flexible array of services** across a variety of network and other linked settings.
Targets people at risk of near-term institutionalization, usually nursing home placement.	**Targets people at high risk** of disability progression and high cost care.
Case managers usually have no authority over care providers.	**Uses tools and interdisciplinary care teams** empowered to manage care across settings.

the appropriate substitution of lower-cost services for high-cost services, and the avoidance of costly inpatient and institutional care (Berger 1996, 150).

Case management professionals agree that the following core functions constitute case management and may be used as a common framework:

- Outreach
- Screening and intake
- Comprehensive assessment
- Care planning
- Service arrangement
- Monitoring
- Reassessment

Although these key sequential tasks are common program components, they are implemented with considerable variation. Long-term care researcher Carol Austin (Austin and McClelland 1996, 2) writes, "An accurate observation is that if you've seen one case management program, you've seen one case management program." According to Austin, four programmatic variables influence the character of case management in any particular setting: targeting criteria, gatekeeping mechanisms, financing/reimbursement, and organizational auspices (5).

The Case Management Society of America has developed the following definition of case management (1995):

> *Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes*

Researchers have developed different case management practice models using different defining variables. For example, Cline has identified three models based on the location from which case management is provided (Austin 1996, 77):

1. Medical care case management (inpatient-based)
2. Catastrophic care case management (insurance company-based)
3. Long-term care case management (community-based)

Applebaum and Austin (Austin 1996, 77) have specified the following three models based on the case manager's type and level of authority in resource allocation decisions:

1. Broker
2. Service management
3. Managed care

Another useful descriptive framework for understanding different types of case management programs has been developed by the American Hospital Association (1992, 149–59). It identifies five basic models of case management:

1. Primary care case management, an early model, vests responsibility in the primary care physician for coordinating all aspects of patient care.
2. Medical case management emphasizes medical monitoring of patients with severe illnesses or injuries.
3. Social case management focuses on coordinating social and economic resources for a nonacute population residing in the community in order to prevent costlier care.
4. Medical-social case management merges medical and social case management by using an array of health, social, and economic resources.
5. Vocational case management centers on assisting persons with disabilities find gainful employment.

Case management programs also vary according to their purposes. For example, some models emphasize cost reduction; others are more advocacy-oriented. While benefits management and utilization management may be components of a case management program, each lacks key defining characteristics that are fundamental to case management as they are described above (Berger 1996, 151).

Case Management for the Frail Elderly

We know that frailty can be a function of physiologic, biologic, socioeconomic, environmental, emotional, and cognitive decline. People who are frail have experienced depletion of reserves in key areas and are often at risk of further physical and functional decline. It is reasonable to assume that a significant percentage of the dually eligible population is either vulnerable to decline or already frail.

There is some evidence that case management properly targeted at these older, frail adults can be effective. A recent study examined the effectiveness of integrating social and medical care for frail older adults—who were already receiving conventional community care services—through the direction of a case manager. Study subjects had fewer hospitalizations and better physical functioning, as well as other reported benefits (Bernabei 1998).

What are the distinctive characteristics of case management for the frail elderly or those with persistent chronic conditions? In a response to a request by the Health Care Financing Administration (HCFA) in the late 1990s, the Institute of Medicine proposed a study to examine the definitions of serious or complex medical conditions and related issues. In the executive summary of the Institute of Medicine's report from that work, the committee recommended that:

> *. . . healthcare plans develop a broad strategy for care management to enable patients and providers to achieve the best possible outcomes for each unique patient or member with serious and complex medical conditions* (Chrvala and Sharfstein 1999).

The committee went on to discuss important aspects of a care management strategy, including: case finding, screening and selection, problem assessment and identification of [the patient's] strengths, development of treatment or care plans, implementation of care plans with an emphasis on proactive interventions, and monitoring of care plan implementation and outcomes.

The committee recommended that throughout the care management process, three principles should be evident:

1. The strategy should reflect a commitment to continuity and coordination of care.

2. The process should include multidisciplinary perspectives and treatments.

3. Patients and their family members should be involved at every step so that the care process incorporates the patient's expectations and preferences and documents the patient's role in achieving treatment goals.

According to Howard Fillit, M.D., and Nancy Leonard, there are several essential elements in good case management for the frail elderly person ("Reduce Risk" 1997; "Focus on Family" 1997). The approach to case management should:

- Use a comprehensive care management model.
- Address the unique medical and social needs of the geriatric patient.
- Manage major chronic care needs.
- Involve consumers in care planning and decision-making.
- Provide appropriate access to specialty care when it is needed.
- Recognize the critical role of respite care services for informal care providers.
- Prevent further decline by focusing proactively on ambulatory care.
- Coordinate care across the continuum.
- Coordinate care management through an interdisciplinary team of professionals (including those with geriatric expertise), paraprofessionals, and family members or other caregivers.
- Include a full range of community-based services in the benefit package.

Selected Approaches Across the Care Continuum

The flexibility of case management has led to numerous applications across the care continuum. Case managers are employed in many settings including hospitals, medical groups, insurance companies, home health agencies, community-based social service agencies, public agencies, senior housing communities, and health plans. The following overview highlights key characteristics of major types of case management for the elderly that are outlined and discussed by White and Gundrum (1995, 162–78) in *The Continuum of Long-Term Care: An Integrated Approach.* Innovative examples illustrate each type.

In the medical setting, several types of case management are observed, supported by a variety of financing mechanisms, including Medicare, Medicaid, managed care, private insurance, and private pay.

Primary Care

Based in physician offices and clinics, this case management model focuses on prevention, diagnosis, treatment, and monitoring.

For example, in 1992, with funding from The John A. Hartford Foundation, Huntington Memorial Hospital, (Pasadena, California) piloted a model partnership between primary care physicians and a community-wide case management program. This partnership was developed to enhance the continuum of care and to improve integration of services. A case manager/liaison—usually a social worker—who was on-call to physician offices provided rapid response for assessments, brief interventions, and linkage to home and community services. At the outset, participating physicians expressed the need for concise information, assistance with patient/family conflicts, and responsible and responsive case management practitioners who would not disrupt the office routine. Major issues identified included anxiety, patient and family conflicts, home safety, transportation, and equipment needs (White et al. 1994).

Acute Care

Case managers based in hospitals and subacute facilities facilitate the flow of care, expedite appropriate discharge, and prevent readmission. This practice is characterized by growing specialization and the implementation of clinical protocols and pathways.

Examples include New England Medical Center, which has been credited for pioneering the implementation of nursing case management. Key program components include:

- Establishing the role of nurse case manager
- Using case management care plans and tools such as critical pathways to achieve clinical outcomes
- Mobilizing ad hoc episode-based groups of nurses and physicians
- Involving patients and families in goal setting and evaluation

Another example is offered by Advocate Health Care, a metropolitan Chicago health system, which has developed a multidisciplinary team approach to case management with many unique features designed to enhance the team's ability to effectively address the complex problems of the frail elderly (Trella 1993).

Advocate and Carondelet St. Mary's Hospital, Tucson, are examples of integrated health networks that have taken the next step to extend case management beyond the hospital walls into the community in order to better integrate care. St. Mary's Hospital's commitment to health promotion and disability prevention has contributed to the early detection of such health concerns as depression, diabetes, and hypertension (Lumsdon 1994).

Private Insurance/ Managed Care

Insurance case managers, sometimes known as utilization review case managers, authorize and verify services and manage benefits and costs for high-cost/high-risk enrollees.

With a decrease in hospital length of stay, the ambulatory care setting is now viewed as the next frontier for managed care case management efforts which offer the potential for averting expensive acute care episodes. For example, in the late 1990s FHP, one of the nation's largest HMOs, saved $8 million over two years as the result of an aggressive case management program based in 16 ambulatory clinics in southern California. Using the risk screening instrument known as P_{ra}, as well as referrals by home health and pharmacists and other case finding approaches, the patient care management program staff identified patients who were at risk for health status decline requiring hospitalization or emergency room services and worked to intervene earlier than might usually occur ("Ambulatory" 1995).

Some payers contract with private medical management firms to manage the care of patients with certain diagnoses or conditions. MedSmart International, a medical management firm headquartered in Costa Mesa, California, calls its trademark system "PATHWORKS Episodes of Care." Its five components include clinical choice confirmation, case management service, care substitution, comprehensive outcome data collection, and case rate pricing structure. MedSmart claims that using this process can decrease overall costs by 15–30 percent ("Using External Case" 1997).

Community/In-Home

The case manager coordinates a broad array of nonmedical care in order to maintain the functional independence of community-dwelling frail elderly. Subsidized senior housing, continuing care retirement communities, and other housing options for older adults may include on-site case management services.

For example, Catholic Charities of St. Paul, Minnesota, has provided case management services for 25 years (Bauer 1997). Organizations such as these, with a particular focus on arranging for nonmedical services such as Meals on Wheels, chore and repair services, transportation, counseling, budgeting assistance, and friendly visitors can offer critical elements of a care plan that enable a frail older adult to continue to safely live at home. Integrating formal services with the informal assistance of reliable and trusted neighbors, friends, and relatives is an important care planning task.

Long-Term Care

Long-term care case managers serve frail elderly with chronic conditions who are living at home or in a facility in order to link them to needed services and to prevent or forestall further disability. Both public and private agencies provide these services.

For example, California's Linkages Program expanded the long-term care case management approach successfully utilized by the state's 2176 Medicaid waiver program (Multipurpose Senior Services Program) to a more broadly-defined eligibility group, including non-Medicaid elderly and younger disabled persons. It has filled many gaps in the continuum of care; in the face of state funding problems, counties have stepped forward to help support its continued operation (White 1995).

Changes in Case Management

Case management expert Karen Zander describes step-wise evolution of the scope of case management practice in which case management roles are driven by provider incentives under financial risk arrangements.

Under the DRG payment system, case management practice in the acute care setting focused on utilization review and discharge planning around episodes of care. With the growth of managed care, case management's focus has extended beyond the hospital walls to the capitated physician practice and has adopted a disease management focus.

In between these two stages, case management assumes a greater role for clinical case management for complex patients in a "combined episode-continuum infrastructure." Ultimately, she predicts, population management in the community is the goal, with self-management replacing case management. She advises organizations to look ahead to the level of managed care risk in their market and to build a case management model that is at least one level above their current one ("Moving Target" 1997). With the need to better coordinate care in a complex, fragmented healthcare system and pressures to achieve greater cost efficiencies, case management programs have proliferated in recent years. Even within a single healthcare system or care network, there may be multiple case management programs. These programs may share common goals but have different objectives and authorities.

Do We Need a Case Manager to Manage the Case Managers?

We have evidence that the number of case managers and of case management programs has been growing rapidly over the last few years. The Case Management Society of America's membership has increased by almost 40 percent in two years. New risk screening tools have been developed, tested, and are in the market for case managers to use. The Medicare+Choice regulations of the late 1990s mandate a risk assessment of enrollees. Among providers and health plans, the question has sometimes been posed as: "Do we need a case manager to coordinate the efforts of all the case managers?"

Author Connie Evashwick (1997) offers practical advice for clarifying roles, streamlining efforts, eliminating duplication, and building effective working relationships in her book *Seamless Connections.* When dealing with multiple external case management programs, she recommends that:

- Each program clearly define its functions, authority, and limits.
- Case managers and their administrators meet to clarify who has precedence and under what conditions.
- Case managers identify ways to share needed information so that they may carry out their jobs more efficiently (73).

Sentara Health System, Norfolk, Virginia, a large integrated health system serving over 175,000 managed care enrollees in southern Virginia, reports a "success story" related to rationalizing and coordinating the efforts of two case management programs under its own umbrella of operations. The primary component of the restructured program is a partnering between the community-based case manager and the hospital-based case manager now merged into a single program called "medical management" under one centralized reporting structure. In January 1996 Sentara completed a pilot test of the new program for two patient groups, including congestive heart failure patients. The pilot met its goals of reducing

hospital admission rates and emergency department visits (“Rethinking” 1996).
Case managers based in different settings across the continuum rely primarily on telephone contacts to communicate with each other. Developing a working relationship based entirely on telephone communication can be a challenge.

The following suggestions offered by Greenville (South Carolina) Health System Provider Services Manager Suzanne Wilson, R.N., to hospital-based case managers who are in frequent contact with “external” insurance company case managers may apply to case managers in other settings as well.

- Be personable and professional.
- Attempt to address your colleague’s information needs.
- Share the clinical pathway that you are using to guide the patient’s care.
- Inquire whether any standardized guidelines (for example, Milliman & Robertson, InterQual) are in use for this case.
- Don’t be threatened by questions.
- Use faxes to confirm information relayed by phone (“Evolutionary Changes” 1996).

Applications in Managed Care

A 1994 study of case management practice in managed care conducted by University of Minnesota researchers with funding from The Robert Wood Johnson Foundation analyzed a sample of 18 of the 20 Medicare risk contractors with more than 20,000 Medicare enrollees, as well as five innovative HMOs that did not meet this criterion (Pacala et al. 1995). The researchers conducted a series of telephone interviews with the medical directors, case management administrators, and case managers from these organizations to explore three major questions:

- What types of case management are being performed for the chronically ill clients enrolled in the HMO?
- How are case management functions organized within the HMO’s structure?
- What future do HMOs see for case management within their organizations?

The researchers found wide variation in case management program goals, location, personnel, case loads, and operating authority. Providers serve as the chief referral source, even in programs with other screening methods. Still underdeveloped in the outpatient setting, case management programs reflect an acute care focus. Although respondents felt that case management was a successful money-saving approach, only 26 percent of the HMOs sampled had actually performed financial analyses. Researchers also discovered that while most programs are small and have not been evaluated formally, 87 percent of the HMO executives surveyed are considering expanding them or adding new ones.
What emerged from the survey findings is a preliminary program typology based on the intensity of contact with and service provision for case management clients. High intensity programs are characterized by small caseloads (below 60 clients), over 50 percent of case manager time spent in direct client contact, and the provision as well as the coordination of services. Programs that scored high in intensity are similar to the case management model associated with the Social HMO demonstrations. In contrast, low intensity programs feature a high caseload (over 100 clients), little direct patient contact, and service arrangement and authorization. With their emphasis on managing hospital days, programs on this end of the intensity continuum resemble utilization review systems.

Respondents identified negative perceptions and misconceptions within their organizations as barriers to the future of case management. However they also cited many positive factors that will favorably shape the development of case management in their organizations such as increased support and resources, improvements in care planning, greater communication among the different members of the healthcare team, and a better understanding of the goals and process of case management among clinicians and administrators.

Collaboration and Communication

To be effective, case management requires active communication and collaboration among a wide range of individuals including the client and family, different types of clinicians in different settings (primary and specialty care, hospital, nursing facility, home care, rehabilitation), staff at community-based services, health plan representatives, volunteers, and case managers.

What is collaboration in case management? In an article in the *New Definition*, case management expert Karen Zander (1992) writes, "Collaboration entails an unspoken acknowledgment of interdependence and demonstrated mutual respect." According to a panel of clinicians who were viewed as highly-collaborative by their peers, the building blocks of highly collaborative practice are clinical expertise, consistency, credibility, assertiveness, and formal communication structures.

"Collaboration entails an unspoken acknowledgment of interdependence and demonstrated mutual respect."

Case managers report that meaningful interaction with providers, particularly physicians, is one of the most challenging aspect of their jobs (Pacala 1997). Physicians place high value on autonomy and individuality, and they are more likely to see themselves as "lone agents of success or failure, " as Don Berwick explains, than as participants in a care process. Because case management is still relatively new, most physicians were not exposed to this method in medical school and residency programs and have limited experience in practice.

However, case manager challenges associated with physician communication and collaboration go beyond independent work styles and scaling the learning curve of an unfamiliar care coordination activity.

- Structural issues play a role. Most case management programs are not based in the physician's office practice. Physicians and case managers rarely have the face-to-face interaction that can help build professional trust and credibility. It is not easy to establish professional relationships when physicians experience only intermittent telephone contact with many case managers in different settings of care.

- Lack of time can also be an obstacle to good communication. Busy clinical practices with large panels of Medicare HMO enrollees can constrain the time available to physicians to promptly return phone calls from case managers, among others, who may need to confer with physicians in order to carry out their client responsibilities.

- Because most case management programs are external to physicians' practices, their goals and benefits may not always be well understood or appreciated. There may be no explicit commitment by the medical practice to support case management and the communication process that it entails. In many situations, the quality of communication and level of cooperation depends on the specific individuals involved.

The successful introduction and integration of case management into a care system involves a paradigm shift and a realignment of roles and responsibilities that may take time to accomplish.

Even case managers who are actually based in the physician office face challenges in relationships, roles, and professional identity, according to the evaluation of a four-year demonstration project funded by The John A. Hartford Foundation in 1992. The Generalist Physician Initiative was based on the premise that the care of frail elderly patients by primary care physicians could be improved by having the physicians work in collaboration with nurses, social workers, physician's assistants, and other healthcare professionals. Case managers reported that establishing positive working relationships with physicians and office staff was critical. While some physicians were eager to work with them, others were initially reluctant—even though they had agreed to participate in the study. The physicians who supported case management viewed it as a valuable extension of their practice, a helpful resource to their patients and themselves, and a service that conserved their time (Netting and Williams 1996).

In a review of the project findings on June 27, 1997, with the ten participating sites, Project Director Frank G. Williams, Ph.D., Arizona State University School of Health Administration and Policy, reported, "Once physicians began to understand their new roles within this study, they also began to appreciate the role of the case manager, social worker, geriatric technician, or nurse partner." The backdrop to this study is the rapidly changing healthcare environment including the "continuing drama of changing roles and relationships of healthcare providers" (Dunevitz 1997).
Based on favorable project outcomes, including improved health status and greater patient satisfaction, reduced utilization of hospital and emergency room services, improved functional abilities, and decreased mortality rates, The John A. Hartford Foundation has funded a new initiative to bring team training and concepts into medical schools, nurse practitioner programs, and social work schools.

Some case management programs have developed formal strategies for improving working relationships with physicians. For example, case managers employed by a large IPA model HMO in California schedule lunch hour visits with physicians on site in their own clinics for the purpose of exchanging information on clients through face-to-face interaction. Because the case managers are assigned to a geographic region of the HMO's service area, they are more likely to become familiar with the primary care physicians who are serving the Medicare-risk enrollees in their caseloads.

A second example comes from SCAN Health Plan, a social HMO in Long Beach, California, in which case managers encountered resistance from newly-capitated physicians who questioned whether they really knew which services were cost-effective for the frail elderly HMO population. Senior Vice President Tim Schwab, M.D., M.H.A., reports that increasing the communication between the case managers and physicians turned out to be the most effective approach to overcoming the initial resistance. Case managers shared patient assessment information via fax and promptly called the physician to report any clinical concerns that were detected during home visits. Schwab added that case management programs succeed if physicians realize that the case manager is an additional resource to help take care of the patient ("Communication Can Yield" 1996).

Targeting Case Management

Experts agree that case management can only achieve effective and efficient outcomes if it is successfully targeted. Case managers must be able to identify clients at risk within the total population. Well-defined risk screening criteria must be developed in order to target those elderly who are most likely to benefit from case management interventions (Kodner 1993, 14).

Risk identification is an ongoing process aimed at enabling healthcare providers to identify and manage the health risks of consumers and to prevent disability or delay further deterioration. It is a mechanism for providing quality service while minimizing cost (NCCC 1995b).

With managed care's focus on population health and efficient management of the capitation dollar, there is a greater emphasis on finding and using triggers for case management referral that are "upstream" from emergency room visits and hospitalizations. According to Howard Fillit, M.D., Corporate Medical Director for Medicare Medical Affairs at NYLCare Health Plans, New York City, early identification of the high-risk elderly is "preventive gerontology." By targeting multidisciplinary resources to the most at-risk individuals, it is possible to prevent further functional decline and poor health outcomes ("Reduce Risk" 1997, 5).

Risk identification is not only important from a clinical point of view. Experts point out that the financial well-being of Medicare HMO plans and providers will depend on their ability to identify and manage members who are high service users, a population that will grow as enrollment increases and the patient mix ages.

Dr. Fillit believes that risk identification should be conducted as part of a formal program that is based on the principles of geriatric medicine and an understanding of the specific needs and characteristics of the frail elderly. This approach to risk identification is evident at NYLCare as well as the following two organizations, whose experience is briefly described.

Cathy Michaels, R.N., Ph.D., of Carondelet Health Care in Tucson, comments, "Risk identification is the glue that holds your case management program together. [Risk identification] is the right service at the right place, in the right time, for the right cost" ("Risk Identification" 1996).

Carondelet's case managers coordinate care across the continuum for frail elderly patients using a nurse-managed community care model. Using a four-step risk identification process, case managers:

1. Classify members with one or more chronic conditions on the basis of risk for needing future medical care.
2. Evaluate the risk level.
3. Target interventions to at-risk patients.
4. Evaluate the results of the targeted interventions.

Kaiser Permanente Center for Health Research has discovered that four items on the Social HMO (SHMO) member health status form correctly classified nearly 91 percent of the Medicare Plus II members as either frail or not frail for the next twelve months. These items are: self-report of poor health, need for assistance with medication management, need for bathing assistance, and advanced age. Every year, Kaiser Permanente Northwest Region Medicare Plus II mails members a SHMO health status form. Returns are optically scanned and assigned a frailty probability score based on electronic algorithms. As required by HCFA, case managers assess all members who report being bed-bound or having deficits in two or more ADLs. They also telephone people with scores of 50 percent or greater in order to identify those for whom a comprehensive in-home assessment is appropriate ("Identifying At-Risk" 1996).

A practical instrument for identifying elders at high risk for health-related crises that lead to expensive hospital utilization and poor quality of life, has been developed by faculty in the Geriatrics Program of the University of Minnesota's Department of Family Practice and Community Health. Known as P_{ra}Plus (P_{ra} is an acronym for "probability of repeated admission"), the tool is a 17-item self-administered questionnaire that focuses on medical and psychosocial capacities ("Geriatric Screening" 1996).

An HMO workgroup convened by The Robert Wood Johnson Foundation recently recommended that P_{ra}Plus become the national standard for screening older populations enrolled in managed care plans. "The survey gives health plans, physicians, and other caregivers the opportunity to work with high-risk patients to develop a coordinated care program that will help to reduce the risk for illness and hospitalization," said Peter Fox, who convened the workgroup ("Slants & Trends" 1996).

Issues to Consider

In *Perspectives on Case Management Practice*, McClelland, Austin, and Schneck (1996, 257–78) discuss important practice dilemmas facing case managers. Their findings are summarized below.

Professional Turf

Is case management a profession? There is disagreement on this point. Some contend that it is really a methodology because persons with diverse educational training provide case management services. The case management literature contains examples of turf battles between nursing and social work, the two professions that lay claim to case management. Recognizing that both professions have important strengths to offer case management, many programs have found that a case management staff that comprises both nurses and social workers provides the best balance and the most comprehensive services.

Is case management a professional role? Not all tasks that fall under case management require professional expertise. While assessment and care planning are sophisticated functions requiring professional knowledge and skills, screening and monitoring may not require professional staff. This "division of labor" has important recruitment, staffing, supervision, and cost implications.

Advocacy and Fiscal Accountability

Case managers may experience tensions between organizational/job expectations for fiscal accountability and their patient advocacy role, which is integral to the professional identity of health and human services providers. The authors note that preventive interventions and a flexible approach to services can obviate far more costly care over time. When fiscal concerns displace client focus, they caution, case managers can lose sight of the need for quality outcomes. The Standards for Social Work Case Management call for the commitment to client-centered services as well as fiscal responsibility, a balancing act that may prove difficult and stressful at times.

Supporting Caregivers

Balancing formal and informal supports is a part of care planning. Case managers must realistically evaluate and weigh the capacity of families to provide the amount and intensity of care needed. Caregiver needs and limits should be addressed.

Policy, Program, and Practice Innovation

In the course of identifying, arranging, and coordinating services for clients, case managers become knowledgeable about the gaps and shortcomings in their local healthcare and social service systems. They are in a position to identify important community needs and policy changes. They can also implement progressive practice principles, particularly those related to client self-determination, cultural diversity, and least restrictive interventions. However, these innovations are likely to emerge only in supportive work environments, the authors note.

Quality Assurance

Quality assurance is an important facet of professional accountability. It is essential for case managers to be able to demonstrate the benefits to society in terms of quality of patient care outcomes, economic savings, productivity gains, and cost reduction. In order to evaluate case management outcomes, longitudinal studies are necessary.

At the organizational level, case management has the potential to help hospitals meet Joint Commission on Accreditation of Healthcare Organizations standards, particularly the patient-focused function "continuum of care" ("JCAHO Doesn't" 1996). And it may also facilitate health plan quality improvement efforts related to HEDIS.

Education and Training

Most case managers in the healthcare field are nurses or social workers who have acquired their case management training on the job. Case management receives little attention in formal degree-granting programs and, as yet, there is no consensus on the most appropriate location or level for educating case managers. In recent years, professional case manager organizations have formed and started to offer training opportunities with recognition for specific levels of achievement. Mentoring is also recognized as an excellent way to help new case managers refine the skills they need to succeed in a demanding role ("Mentoring Offers" 1997).

Case Illustrations

Recent demonstrations using case management approaches reflect the need to find more effective ways to organize and deliver care for the chronically ill under managed care financing.

The first two illustrations are demonstration projects funded under The Robert Wood Johnson Foundation's "Chronic Care Initiatives in HMOs." They provide strategies for better integrating the delivery of chronic care through case management. These projects share two major objectives: integrating case management into the ambulatory care setting and developing a proactive case management model in which the emphasis is on the early comprehensive management of high-risk Medicare HMO members.

A third example described a case management program designed for at-risk elderly patients piloted by Carle Clinic, a multi-specialty group practice in central Illinois.

The Community Resource Connection: A Collaborative Model for Chronic Care

Blue Cross Blue Shield of Oregon, Legacy Health System, and eight independent primary care physician groups located in the Portland, Oregon, metropolitan area collaboratively developed an early intervention program targeted at community-dwelling elderly aged 65 and older who were at risk for physical or emotional health problems. The demonstration, known as the Community Resources Connection, explores the potential of managing and coordinating chronic care services in an independent practice association setting. The pilot project identified at-risk enrollees and referred them to one of three levels of care coordination in order to maximize the appropriateness of services and to promote functional well-being and disability prevention.

Key to the success of this demonstration is the resource specialist role. The individuals who serve as resource specialists, either nurses or social workers, are highly experienced community case managers who perform the following key activities:

- Conduct phone interviews of the at-risk patients (approximately 25 percent) identified from the mail-in screening questionnaire administered to the Medicare-risk HMO enrollees who are patients of the participating physician groups.
- Perform an in-home assessment of those patients who have difficulty communicating by phone and/or have complex needs.
- Triage the at-risk patients to one of three levels.
- Provide information and coordination as appropriate to the individuals in each group.

The twin goals of the resource specialist are to:

1. Identify present or future needs of the patient that can be addressed through community resources or by the primary care physician, acting as an extension of the primary care doctor's office.
2. Make appropriate and timely linkages and increase the awareness of available local resources among patients, their families, and the primary care clinic staff, based on extensive knowledge of community resources.

In February 1996 following a one-year pilot, the three-year project implemented a randomized, controlled trial involving 2,500 patients at eight different primary care practice sites—four intervention clinics and four control clinics. After the one-year trial, the patients in the control clinics were offered access to the intervention. The evaluation assessed the impact of the intervention on:

- Patient functional status and mental health
- Medical costs, hospitalizations, and emergency room visits
- Patient satisfaction with healthcare received
- Physician and nurse satisfaction with this community-based care model

The Community Resource Connection has been well received by patients and the primary care practices. Project investigators report that they were not fully prepared for the numbers of patients who were initially referred by physicians eager for this type of assistance. Patients in levels 1 and 2 (74 percent and 23 percent, respectively) appreciated the information and referral services provided by the resource specialists, while those in level 3 (approximately 4 percent) who required more intensive assistance valued the skillful coordination and guidance in navigating the complex healthcare system (RWJF 1996).

Integrating Case Management into the Primary Care Setting: A Feasibility Study

Health Plan of Nevada (HPN), a federally qualified and state-licensed HMO operated by Sierra Health Services, Inc. (SHS), offers a Medicare-risk product, Senior Dimensions, which serves approximately 29,000 senior citizens. A mixed group/network model HMO, HPN contracts with another SHS subsidiary, Southwest Medical Associates (SMA), to provide primary and multi-specialty care to nearly 80 percent of its members. HPN offers a full range of services including ambulatory care, inpatient acute care, subacute care, rehabilitation services, nursing home care, home health services, mental health and substance abuse services as well as a hospice program. Risk assessment and case management programs were added to better serve the frail and chronically ill.

Referral statistics from the case management program enabled HPN to recognize the need for early intervention and ongoing identification of members whose health declines after they enroll in the plan. Specifically, 45 percent of referrals to case management were initiated at the time of hospitalization; only 12 percent were made by the physician's office. As stated in the feasibility study report, "in the absence of a systematic means for referring members to complex case management from the primary care setting, the process becomes erratic, and opportunities are lost for early intervention to prevent the decline of patient functional status and to assist patients in accessing services appropriately."

HPN obtained a planning grant from The Robert Wood Johnson Foundation to design and implement a model of care that would improve the identification of high-risk members and better integrate case management into the primary care setting and to evaluate the feasibility and replicability of the model.

A multidisciplinary project team was formed to develop interventions that would better serve at-risk patients who would benefit from care coordination. This team recommended:

- Educating primary care staff on case finding and case management services
- Assigning a case manager to the clinic site
- Forming an expanded primary care team at the pilot site comprising the primary care physician, nursing supervisor, and service representative as well as new team members including the case manager, resource coordinator, and clinical pharmacist
- Performing risk screening on an annual basis to capture changes over time in member health and functional status

A three-month pilot study was conducted during the summer of 1995. A pretest/posttest design was used to evaluate the new care model's impact on case management referral patterns and services as well as provider/staff knowledge of case management.

HPN succeeded in developing a new ambulatory care-based case management model and demonstrated its feasibility by:

- Increasing case management referrals from the clinic setting
- Increasing the number of contacts and average time spent providing case management to high-risk members
- Increasing clinician and staff understanding of case management services
- Identifying high-risk Medicare HMO enrollees through mailed risk screening surveys and subsequently referring them to case management
- Targeting members with potential medication problems

Due to the limited time frame, it was not possible to determine the effect of the model on patient outcomes or costs.

One of the lessons learned from the pilot is that a major culture change is required in order to fully integrate case management services into the primary care setting, a paradigm shift that requires more than three months to achieve. The case manager became a resource to the primary care team during the course of the pilot project but did not regularly meet with the team to review patients. Communication with the provider was informal and written documentation of case management services did not appear in the medical record.

In November 1996 HPN began to replicate this primary care-based model of care coordination in two clinics as part of its Social HMO (SHMO) demonstration with HCFA. The SHMO demonstration will be expanded to additional SMA clinics and several network providers as well. A comparison between demonstration and control sites will examine member outcomes and evaluate the effectiveness of the Social HMO project (Grower 1997).

Case Management Demonstration at Carle Clinic

A case management program designed for at-risk elderly patients piloted by Carle Clinic, a multi-specialty group practice in central Illinois, has led to improved self-reported health status and lower medical utilization. Carle Clinic was one of ten sites selected to participate in The John A. Hartford Foundation's Generalist Physician Initiative to improve primary care for the elderly.

Carle Clinic developed case management plans for 579 patients at four of its 14 offices. The test group, comprising elderly persons identified by their physicians as having a high risk for serious health complications and who agreed to participate in the study, was compared with a control group of 486 patients through record review. In addition to lower mortality, patients in the test group used fewer than half as many hospital bed days by the second year of the study and had slightly lower hospitalizations and emergency room visits overall.

Patients were enrolled in the two-year program in 1993. At enrollment, they were assessed for health status, psychosocial needs, and environmental needs at home. The nurse case manager and primary care physician met with every patient and family to engage them in a care plan that they developed collectively. The nurse case manager also conducted an in-home assessment to identify and evaluate needs for a variety of services, such as home care and heating bill financial aid, arranged for needed services, and monitored each patient in the test group based on the individualized care plan that was developed. The nurse case manager served as an information resource for the patient and family and served as a coordinator for home care and hospital discharge planning, as appropriate. Program costs were estimated to be $21 per member per month for year one and $19 per member per month for year two.

When The John A. Hartford Foundation grant ended, Carle Clinic decided to expand the case management program and to use the program delivery model as the central feature of its Medicare-risk package ("Carle Clinic" 1997).

Care Coordination in a Dually Eligible Demonstration

The State of Minnesota launched a demonstration for the dually eligible in 1996 called Minnesota Senior Health Options (MSHO). In a series of focus groups, held first with health plans and providers, and then with beneficiaries, the importance of case management and communicating with physicians was revealed. From the health plan/provider focus group, participants raised the issue of role definition and responsibility for overall care management of these clients. There was uncertainty about how the physicians worked with care coordinators and whether communication and cross-site collaboration could be improved. Also, the different methods of care coordination across plans and providers were discussed, with an interest in trying to ferret out best practice. Focus group participants supported the care coordination aspect of MSHO strongly; however, arriving at the most effective and efficient methods for providing care coordination was seen as an evolving process. Where more than one care manager was involved in an enrollee's case, there could be confusion about roles and responsibilities—this problem was discussed especially with clients living in the community. There was a belief that this problem may diminish with experience.

In the beneficiary focus groups it was clear that the care coordination aspect of MSHO was "the heart" of this demonstration. Participants were complimentary about their care coordinators. These enrollees felt that the coordinators were their advocates and were attentive to the clients' needs—even anticipating needs that the clients themselves didn't think about. There seemed to be good relationships between client and their care coordinators. In story after story, focus group participants described situations where problems arose and their care coordinators resolved them. These stories were told with almost audible relief at not having to navigate the system themselves. The participants reported that the care coordinators provided the following services:

- Arranging home service for them when needed, such as home care nurses, to help the participants avoid institutionalization
- Providing information on new procedures or new treatments
- Visiting them at home or in their rooms at the nursing home
- Providing home safety equipment such as tub chairs, toilet seats, grab bars
- Checking on them after hospitalizations
- Arranging coverage for items that were initially denied coverage
- Arranging for preventive services at home

A few beneficiaries did not fully understand the role and expectations for care coordinators—they were not sure of the limits of the role. Those who were nursing home residents wanted a schedule of when the care manager could be expected at the home. The community-residing residents were not always sure just when the care manager should be called. Some called for any reasons; others only when they were experiencing some difficulty that they could not resolve on their own.

Comments from focus group participants

"She [my Mom] got things that I didn't really think she could get, some of the meds she always had to pay for and like the high seat for the toilets and stuff like that. We never knew that. It helped out to get [hand] railings. Her coordinator told her about how to get handrails and all these type things. It was very shocking. . . much more than we imagined. It took a lot of stress off her. [Mother would say] 'How am I going to get this?' You call your coordinator and she'll take care of it."

"When I talk to the coordinator, they come over to the house. They ask me about everything I need. I said I didn't need anything. They said I needed a railing for my tub, a shower holder and shower chair. All that stuff. Things that I didn't know I needed. Now I am using it. I'm very glad that this program is there for the seniors."

"If I have any problems, why I call Sonja [the care coordinator]. She corrects them for me. Before that, I'd have to worry about how to do it. Now I can just call Sonja. I can rest."

"Sonja called. She wanted to come over and talk to us. I said my doctor has been threatening to put me in a nursing home. . . She [the care coordinator, Sonja] *says: 'No, no, you call me. I want to check and see what you need around here since your stroke.' And she did and she got it. The transition was easy going from* [hospital to home]*. Before, I didn't have anybody to call and find out. Now I've got someone. It's great."*

Models in Use for the MSHO Demonstration

Metropolitan Health Plan

During an educational forum in 1997 Jernell Walker, R.N., Coordinator, Metropolitan Health Plan (MHP), provided an overview of how MHP approaches case management for Minnesota Senior Health Option (MSHO) clients. The following are written proceedings of her presentation.

At MHP, case management and care coordination of the Minnesota Senior Health Options (MSHO) members are part of a health wellness continuum. This continuum integrates all available resources and services within our network and through our supported sites. We want to maintain and enhance each individual's personal level of wellness.

MHP's eight care coordinators and case managers coordinate care over the telephone. When a person is in the hospital, we have a health plan inpatient case manager on site. We have a contract with Coordinated Home Services of Hennepin County to provide services on site in the community and a contract with Optage to provide on-site case management of members in skilled nursing facilities.

Our main goal is to help seniors make informed decisions, enabling them to stay in the community; to help seniors problem solve; and to connect seniors who have no support systems to resources in the community.

Our case management model has five components:

1. Assessment of health status

2. Case manager determination

3. Coordination of services

4. Monitoring

5. Reassessment of health status

The assessment of health status includes an initial health risk assessment survey. During this assessment, we gather as much information as we can to determine who will be the case manager.

MHP case manages, by telephone, those who are low risk. Coordinated Home Services manages those at moderate risk who need hands-on community-based services. Optage—a provider system—manages those at high risk. Monitoring involves comparing our initial database with current utilization data.

Reassessment is done on an established timetable. Sentinel events require weekly reassessment until resolution. For people living in the community, we reassess health status and care plans every three to six months. We also complete an annual MSHO screen for members who are deemed nursing home certifiable and who are living in the community.

Hennepin County Coordinated Home Services

Maryon Kellar, B.S.N., P.H.N., Supervisor, Hennepin County Coordinated Homes Services described how her organization provides case management services to moderate-risk, community-dwelling MSHO clients. These are the written proceedings from her presentation.

Hennepin County Coordinated Home Services began working with Metropolitan Health Plan in March of 1997, but we spent a lot of time the year before that preparing for this effort. In June of 1997, we started with UCare Minnesota [another health plan]. We are now beginning talks with Medica [the third health plan participating in MSHO].

We have a lot of experience—we have been at this for 14 years. We have approximately 55 case managers who work for us; more than 35 work with clients who are on the Alternative Care and the Elderly Waiver programs. We just recently started a program in collaboration with Services to Seniors in our county.

In Hennepin County most of our case managers are public health nurses, although we do have five social workers on staff. With the addition of Services to Seniors, we added 12 more case managers who are social workers. So we are getting a broad perspective on case management for our clients.

We began by forming teams. We have five to seven members on each MSHO team. We divided them

geographically because one of the goals for our whole organization is to do geographic location of case managers. We followed this same perspective when we looked at how to do this for MSHO, and this seems to be working quite well.

We've had regular meetings with the managed care organizations and with case managers. In that way, the case managers have had a lot of input on how this will work. I think this is why it has been as successful as it has. They have been involved in developing the policies and the procedures. They are modifying these as they go, smoothing out the rough spots.

We have a large case management manual that we put together. Sue Bulger, another of our nursing supervisors, can take great credit for this. She has worked with a group of case managers from our county to develop this. That committee continues to define what case management is for us, using this model and integrating with MSHO.

One of our challenges for case management is getting information on the client. It is difficult to get information, especially when you are working with Hennepin County, which is a teaching hospital, because people tend to have about six different doctors when they are in the hospital. When you call and try to get information, no one knows the comprehensive picture of the client.

An advantage we have within the county system is our e-mail system that allows us a fast way to transfer information between settings electronically. We always follow this up with a paper copy.

Being able to coordinate care with Optage (a care system) at the nursing home has allowed us to really plan well for the client. Those of you who work in home care know that you have to do a little planning. Knowing that the client is going to be leaving and being able to plan for those services is very important.

Hennepin County Community-Based Long-Term Care

Philosophy and Definition of Case Management

Case management is a client-centered service that respects the individual's dignity, rights, values, and preferences. Case managers strive to promote enhanced quality of life and highest level of independence and autonomy consistent with the individual's capacity.

Case management incorporates the following core functions:

- Completion of a comprehensive and standardized assessment and periodic reassessment of a client's needs and strengths
- Identification of client-centered goals
- Development of a high-quality and cost-conscious care plan
- Coordination of formal and informal resources
- Ongoing management and monitoring of client status and service delivery to ensure appropriateness of care and optimal use of public and private resources

Case managers are public health nurses and social workers who provide information and advocacy while coordinating the formal care network with the client's informal support system. Case managers strive for flexibility and innovation to obtain the most appropriate, highest-quality, and most cost-effective long-term care services available.

UCare/University Affiliated Family Practice Clinics

Linda Kramer, L.S.W., Care Coordinator, University Affiliated Family Physicians (UAFP) Clinic, described her role as a clinic-based MSHO care coordinator during an education forum in 1997. These are the written proceedings from her presentation.

University Affiliated Family Physicians (UAFP) is a group of family practice clinics affiliated with the University of Minnesota Medical School. Physicians who staff the clinics are University faculty and residents.

I am the care coordinator for patients from these clinics who sign up for MSHO. Our approach with MSHO is clinic driven. Clinics differ in the way I work with them, depending on factors like staff turnover, staff job descriptions, and level of assistance needed at each clinic.

As UAFP's only care coordinator, I make an initial visit to the member's home to introduce myself and explain my role. Then I do a risk assessment to determine the member's risk status for home care

and nursing home placement and for necessary referrals. I may set up services for assistance in the home or may provide education, resources, and information. If the patient has not been seen recently at the clinic or is new to the clinic, I would encourage him or her to make an appointment and see a physician. After I do the home visit, I consult with the physician, especially if I have questions or concerns about the patient.

After I visit a client, the team initiates a care plan and evaluates risk status. I classify the patient as low, moderate, or high risk. For someone who is considered low risk, I would make a follow-up phone call in three to six months. People at moderate risk need more assistance from the care coordinator to help coordinate their care. High-risk individuals need further intervention for them to stay in the community. Interventions might include home care services/PCA, alternative housing, therapy, adaptive equipment, or nutritional consultation. Risk identification is an important component of what we do, but I want to stress that when you identify risk, it needs to result in intervention, not just a classification.

A unique feature of our model is that the care coordinator follows each client to each healthcare setting. If a patient were admitted to the hospital, a UCare healthcare management nurse would be notified of the admission and would share information on the patient's status with me. I would work with the hospital discharge planner on the discharge planning, finding out what's needed at home. If a patient went into a nursing home, I would coordinate the care for the first six months. Optage would take over case management after the resident had been there six months. In our system, Optage also case manages enrollees who sign up for MSHO while they are in the nursing home. I would work with the physician and nursing home to implement discharge plans with the resident. Because I've been following the resident through the continuum of care, appropriate services would be in place at the time of the discharge.

I do work with Hennepin and Ramsey Counties, and what they are contracted to do varies in regard to preadmission screenings. Hennepin County does the full screening, and then they do the care plan and assign a case manager to follow up. Ramsey County would just do the screening and then I would take over and do the care plan and the case management. So where the person lives is important in our plan because we do have the variation in what the county has contracted to do. Our enrollment started June 1. Now we have 65 people from the community enrolled in MSHO. MSHO members have been enthusiastic about the addition of a care coordinator. They appreciate the fact that there will no longer be the Medicare paperwork.

We are moving beyond the role of discharge planning to integrated care management that incorporates the concepts of disability prevention into the plan of care across the continuum. It's a coordinated system that links management of care across time, place, and profession throughout the progression of a chronic condition.

UCare Minnesota MSHO Care Coordination

- A team approach to care delivery is facilitated by a care coordinator who is either a nurse practitioner, nurse, or social worker. Other team members include the physician and additional members as needed such as a pharmacist, a rehabilitation therapist, and a psychologist.
- The goal is to deliver health services to the individual, whether he or she is residing at home, in an assisted living facility, or in a nursing home rather than the individual having to move to the health service. One intent of MSHO is to assist the member to reside in the most favorable environment, given his or her health status.
- Upon enrollment into the program, the member receives a risk assessment, which is arranged by the care coordinator to identify any significant issues. This assessment has an emphasis on disability prevention and a goal of decreasing the potential for health crisis.
- The care coordinator reviews the risk assessment and develops a care plan with the member, involved family members, and the care delivery team. The care coordinator also coordinates care with other current providers. The member is involved in determining his or her health goals, including advance directive details, activity levels, and goals for quality of life.
- Any prior authorizations or referrals are made by the care delivery team with the member and are facilitated by the care coordinator.
- The care coordinator is in regular contact with the member, and the member or family can contact the care coordinator with any questions or concerns.
- The care coordinator provides health education to the member and facilitates the coordination of health and social services, removing some of the complexity around accessing care and services.

Case Management Challenges

Case management has become a widely accepted approach for managing care of the frail elderly. A comprehensive, effective case management approach benefits the patient, family, providers, and payers. However, there are challenges that require serious attention by any organization seeking to create or refine its case management program.

The HMO Workgroup on Care Management (1999) described many of these challenges in their report: *Geriatric Case Management: Challenges and Potential Solutions in Managed Care Organizations.* (Some of these challenges have been discussed previously in this report). They include:

- The interface between physicians and care managers
- The ability to consistently provide services and administer a benefits policy in a complex delivery system environment
- The ability to actively engage clients and their families
- The ability to link to community-based and home-delivered services effectively
- The training needs and skill sets of case managers
- The ability to set specific goals to monitor case management performance
- The ability to “close a case” and “discharge” clients from the case management service

More than a decade ago, James Callahan (1989) critically examined the promise and limitations of case management. He called for a broader array of solutions to the fragmentation in the healthcare system that case management attempts to address. His proposed solutions include:

- Empowering older adults and their families through the dissemination of information about benefits, accessing services, and identifying important symptoms that signal the need for clinical attention
- Expanding income supplements so that the elderly may directly select and purchase needed services in the marketplace
- Increasing options for enrollment in more inclusive, less fragmented organizations
- Redesigning jobs in order to reduce the multiplicity of healthcare workers who serve older adults in their homes and medical settings

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