U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

RATIONING CASE MANAGEMENT:

SIX CASE STUDIES

November 1994

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-282-92-0047 between DALTCP and the MEDSTAT Group. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Ruth Katz.

RATIONING CASE MANAGEMENT:
Six Case Studies

Mary E. Jackson, Ph.D.

The MEDSTAT Group

November 30, 1994

Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-282-92-0047

This report was prepared by The MEDSTAT Group under contract to the Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy under contract HHS-282-92-0047. The views and conclusions presented in this paper are solely those of the author and do not necessarily reflect the views of the HHS. The author alone assumes responsibility for the accuracy of the information presented in this report.

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

This report would not have been possible without the cooperation of administrators and case managers from the programs upon which this report is based. In particular, special thanks go to the following individuals who were instrumental in arranging and participating in the site visits and who also took time to review drafts of this report: Teri Moore of Senior Options, Franklin County, Ohio; Kandy Witte from the Elderly Services Program, Hamilton County, Ohio; Dee O'Connor and Johanna lerna of the Home Care Program for Elders, State of Connecticut; Marta Aceda of the Aging & Adult Services Administration, State of Washington; and Susan Dietsche from the Division of Senior and Disabled Services, State of Oregon. During the site visits dozens of case managers, several local program administrators, and some providers provided invaluable information and insight into the case management process in their respective programs. They are too numerous to name individually, but this report would not have been possible without their participation. The work represented by this report also benefitted from the input and advice of the following people: Pam Doty, Ruth Katz and Mary Harahan from the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Resources; Bob Applebaum, Scripps Gerontology Center, Miami University; Monika White, Senior Care Network, Huntington Memorial Hospital, Pasadena; Joan Quinn and Myra Kerr, Connecticut Community Care, Inc.; and Barbara Schneider, consultant.

I. INTRODUCTION

This study was conducted in response to the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services' need for information on home and community-based services programs that purposely ration case management services to their clients, based on client need. The government's need for this information was activated by the requirements set forth in the Clinton administration's home and community-based services program, proposed as part of the Health Security Act.[1] The proposed legislation called for a Federal/State partnership targeting home and community-based long-term care services to persons with severe disabilities, regardless of income or age. Case management was stipulated as a required service for assessment and care planning, but States would have had the option of including *ongoing* case management in the service package.[2]

The traditional delivery system for home and community-based long-term care services, as embodied in many federal, state and locally funded programs, has emphasized the pivotal role of case management for access, eligibility determination, assessment, care planning, service arrangement and quality assurance. The majority of such programs provide the full spectrum of case management services to all clients, and do not consciously target a subgroup of clients for more or less intensive ongoing case management and monitoring. This model tends to prevail, regardless of the presence or intensity of the client's need for ongoing case management. The States' option to offer ongoing case management to selected individuals, as specified in the Health Security Act, is an approach to the delivery of long-term care with which most States have not yet had experience. In order to be in a position to offer technical assistance to States on this issue should the Clinton plan or similar legislation for the establishment of a new federal long-term care benefit become enacted, ASPE requested that the contractor identify and review programs around the country that have experimented with models that do not universally prescribe case management. Thus, the purpose of this study was to develop a series of case studies, describing:

- the organization and role of case management in these programs;
- types of clients served;
- how clients receiving case management are identified (triaged); and
- approaches and challenges to quality assurance when case management is minimized.

[1] S.2537, 103rd Congress of the United States of America, Second Session.

[2] The home and community-based component of the Health Security Act also specified that States participating in the long-term care program would be required to offer both agency-administered and consumer-directed personal assistance services. While consumer-direction, defined as allowing consumers to select, manage, and train their own providers, has implications for the way in which case managed services are delivered, this report does not focus on consumer-directed programs per se, although several of the programs reviewed do provide this option to their clients. Where these services are offered, their implications for the practice of case management is discussed.

This study focuses on six community-based long-term care programs that deliberately vary the nature or intensity of case management to conform to a client's need for assistance in managing their long-term care service packages. In general, these programs deviate, to a greater or lesser degree, from the traditional full-spectrum model of case management typically found in most programs. They treat ongoing case management like any other long-term care service--one that must be justified based on client need.

What follows is a description of the six programs identified as examples of attempts to classify clients according to the intensity of case management need. Five of the six programs triage clients into two or more levels of case management. These programs include:

- Options for Elders Demonstration (1990-1991)
  Ohio Department of Aging

- Senior Options
  Franklin County, Ohio

- Elderly Services Program
  Hamilton County, Ohio

- Aging & Adult Services Administration (home care program for the elderly)
  State of Washington

- Home Care Program for Elders
  State of Connecticut

One other program is included in this review although it does not triage clients into different modalities of case management, as do the other five programs:

- Division of Senior and Disabled Services
  State of Oregon

All long-term care clients in Oregon's programs (even nursing home residents) receive case management. This program was included here because the case management delivery system in Oregon is sensitive to variations in client need for case management by allowing case managers to exercise professional judgement in scheduling the frequency of monitoring contacts.

The information for this report was generated as a result of site visits to each of the currently operating programs;[3] activities during the site visits included discussions with administrative personnel, case managers, and in one instance, providers. A site visit was conducted at each of the existing programs between October 1993 and October 1994. Two site visits were made to Connecticut's Home Care Program for Elders, once during October 1993 and again in June 1994. The site visits to Franklin County's (Ohio) Senior Options program and to Hamilton County's (Ohio) Elderly Services Program were conducted in June 1994. The State of Washington's Aging and Adult Services Administration sponsored programs were visited in September 1994, and Oregon's Division of Senior and Disabled Services in October 1994. Administrators of each of the programs visited provided documentation such as client flow charts, program rules and regulations, eligibility criteria, and rules/guidelines for determining level of case management. The next sections of this report describe in detail the salient features of each, with particular attention to the role of case management and to the methods of case management triage employed.

[3] Ohio's Options for Elders Demonstration ended in 1991. Information on this program was attained through interviews with Bob Applebaum, who conducted an evaluation of the demonstration, from his evaluation report (Applebaum R, Ciferri W, Riley T, Molfenter C: Evaluation of the Implementation of Ohio's "Options for Elders" Demonstration, Scripps Gerontology Center, Miami University, Oxford, Ohio, July 31, 1991.), and from staff in Franklin County's (Ohio) Office on Aging who had participated in the demonstration.

II. OPTIONS FOR ELDERS DEMONSTRATION (1990-1991), OHIO DEPARTMENT OF AGING

SENIOR OPTIONS, FRANKLIN COUNTY, OHIO

ELDERLY SERVICES PROGRAM, HAMILTON COUNTY, OHIO

A. Background

Two county-based community long-term care programs in Ohio are included in this report--Franklin County's Senior Options program in the Columbus area and Hamilton County's Elderly Services Program in the greater Cincinnati area. Both programs are an outgrowth of a demonstration program funded by the Ohio Department of Aging in 1990-1991, and operated in Franklin County and nine rural counties in southeast Ohio. The goal of this demonstration was to test a community-based long-term care model that included a single point of entry combined with a triage approach to case management that would provide an integrated continuum of community-based long-term care for elders. Because the two county-based programs were so heavily influenced by the Options for Elders Demonstration, a description of the demonstration is provided here, as well as the case studies of the two county programs. Information for this report comes from conversations with Bob Applebaum of the Scripps Gerontology Center, a 1991 evaluation of the Options for Elders program conducted by Dr. Applebaum and his colleagues, and interviews with staff from the Franklin County Office on Aging, the Central Ohio Area Agency on Aging, and the Council on Aging of the Cincinnati Area.

B. Options for Elders Demonstration

1. Overview

A single point of entry was developed as the undergirding of the entire delivery system in this demonstration, and was organized under the Information and Assistance (I&A) function. The I&A function was managed locally in the southeastern Ohio site by the Buckeye Hills-Hocking Valley Regional Development District Area Agency on Aging out of its Marietta office and in Franklin County by the Franklin County Office on Aging in Columbus. By calling one central telephone number residents received information about the types of services available to address their long-term care needs. The I&A function, however, went beyond typical information and referral function in that I&A workers served a triage function as well. Depending on the needs presented over the

phone, and based on a, short over-the-phone screening assessment, the I&A worker would classify the caller as needing only information; needing information as well as some assistance or advocacy in accessing services; or needing case management to assist in accessing services.

Clients receiving services through the demonstration were triaged into one of three groups:

- Basic Assistance
- Ongoing Assistance
- Case Managed Services

If, on the basis of the telephone screening, it was apparent that the client needed Options-funded services (homemaker, home-delivered meals, respite, adult day care, chore service, or medical transportation) for less than one month and met self-reported eligibility requirements, the client was triaged into the Basic Assistance mode. If the I&A worker could not secure services for the client through other funding sources then s/he could order up to one month's service with a local provider. In order to become a Basic Assistance client the cost of care per month could not, in most instances, exceed $200. The use of Basic Assistance evolved over time to where the counties used it as a method of providing immediate services to recently discharged hospital patients. Also, in some instances, the length of time on Basic Assistance was extended from four weeks to six-eight weeks to meet post-hospitalization needs.[4]

The two demonstration sites processed Ongoing Assistance clients somewhat differently. In the southeast Ohio site, I&A workers contacted the providers who would verify the information taken by the I&A worker over the phone. When a client was classified as potentially needing ongoing assistance by the I&A in the Franklin County site, however, a case manager would make a home visit to verify the information received during the telephone screening, including a verification of financial eligibility. Upon verification of functional and financial need, the case manager would authorize services.

Monitoring of Ongoing Assistance clients in the Southeastern Ohio site was conducted by I&A workers with telephone calls to recipients every three months, contacts with providers, and random home visits. Franklin County I&A contacted Ongoing Assistance clients immediately after service initiation, and then three months later, with a yearly in-home visit to verify continuing eligibility and to reauthorize services as appropriate.

[4] Applebaum R, Ciferri W, Riley T, Molfente, C. Evaluation of Implementation of Ohio's "Options for Elders" Demonstration, Scripps Gerontology Center, Miami University, Oxford, Ohio, July 31, 1991.

2. Role of Case Management in Options for Elders Demonstration

I&A triaged callers to Case Management under one of four conditions: a) when a client had multiple service needs; b) when a client had a mental health problem; c) when a client was unable to receive telephone monitoring (under Ongoing Assistance); or d) when a client was unable to respond to telephone monitoring (under Ongoing Assistance). Upon referral to case management, the case manager would make a home visit where a comprehensive assessment was conducted, care plan developed, and services authorized. Ongoing monitoring by phone and home visits were conducted as needed by the case manager. Not all clients referred to Case Management remained in this modality, but were referred to Ongoing Assistance if their circumstances allowed. Case managers in the southeastern Ohio site were drawn from the same agency that conducted I&A, but in Franklin County the Central Ohio Area Agency on Agency collaborated with the Franklin County Office on Aging to provide case management services.

3. Client Profiles in the Options for Elders Demonstration

Statistics reported by Applebaum et al. indicate that the vast majority of Options demonstration clients were *not* triaged into Case Management.[5] Most clients (75%) received information and assistance only. Only about 11% of demonstration clients were triaged into the Care Management modality.

Eligibility criteria for Options required evidence of some disability, but not necessarily severe disability; nor did Options require any need for skilled attention. To be eligible for Ongoing Services an applicant had to have "mild but long term deficits in functioning and informal supports." Eligibility criteria for Case Managed services included weak or absent informal supports and *one* of the following: a) inability to perform one or more of 7 ADLs;[6] or b) a behavioral or mental health problem that could lead to premature institutionalization or inability to provide for one's own health/safety, primarily due to cognitive or psychological conditions.

Overall, persons enrolled in Options were found to be less disabled than those receiving services under PASSPORT, Ohio's Medicaid home and community-based services waiver program. This was to be expected since the profile of PASSPORT clients should be similar to the functional profiles of nursing home residents since PASSPORT was (and is) targeted to the population who would otherwise be institutionalized.

Despite an overall disability level less severe among Options program participants than PASSPORT clients, Applebaum et al.. found variation in disability levels between Options Case Managed clients and those receiving either Basic or

[5] Ibid.
[6] ADLs included walking/wheeling; bathing/showering; dressing/undressing/grooming; eating; managing medications; toileting; and transferring.

Ongoing Assistance.[7] For example, while 61% and 45% of Basic and Ongoing Assistance clients, respectively, were disabled in bathing, 72% of Case Managed clients were disabled in this ADL (compared to 94% of the Medicaid PASSPORT recipients). The differences among Options clients on other ADLs were not as striking; for example, 24% of Basic clients were disabled in transferring, 20% of Ongoing Assistance clients, and 34% of Case Managed clients (78% of PASSPORT recipients).

Applebaum and colleagues also reported that persons assigned to the alternative service modalities tended to receive differing service packages. Basic Assistance clients typically received one service only, most commonly home-delivered meals. Ongoing Assistance Clients usually used one or two services, and the most common services for this group were home-delivered meals and homemaker services. Case Managed clients averaged two services per person, with home-delivered meals and homemaker services being the most frequently received, but approximately 40% also received personal care services.

4. Duality Issues in the Options for Elders Demonstration

A key goal of the demonstration was to provide appropriate and timely services to elders in a geographic area in a streamlined fashion by applying the concept of medical triage to system entry and service delivery, while at the same time assuring the safety of clients and the quality of services authorized by the program. Related to these goals, the evaluation conducted by the Scripps Gerontology Center found that "...Options' clinical operations met the standards of good clinical practice."[8] That is, they found that: a) I&A telephone screeners, accurately determined client level of functioning; b) the program was "consumer- centered", giving priority to needs identified by clients; c) in general, clients triaged to a given group were assigned to the appropriate intervention modality; and d) those not receiving case management services per se were functioning well in its absence. One of the concerns highlighted in the evaluation, however, was that because there was a premium placed on consumers defining their own needs, needs which clients were reluctant to acknowledge risked going unmet, e.g., mental health needs.

C. Franklin County Senior Options

1. Overview

When the state-sponsored Options for Elders demonstration terminated enrollment in July 1991, Franklin county responded by passing a voter-initiated property tax levy of $.75 per $1,000 to generate the means to continue funding community-based long-term care services for its residents. The levy was approved in June 1993 by 66.5% of the voters. Franklin County Senior Options program began enrolling clients in

[7] Op cit., 1991.

[8] Ibid.

January 1993. The levy will be up for renewal in 1997, and will again be placed before the voters.

The current Senior Options program maintains all the essential features developed during the demonstration phase of the program, but program administrators cite the additional flexibility that is now possible due to local control. One of the ways in which they operationalize this flexibility is by providing immediate services not only to Basic Assistance clients (short-term need), but also to those with long-term needs prior to an assessment being performed. Program administrators also stressed that flexibility is critical to providing the client with choice in addressing their needs; they perceive Senior Options as following the “disability, consumer-driven” model in this regard. They stated that their commitment to this approach is evident in their hiring practices where they develop a “test question for new hires”, the response to which indicates the potential hire's perspective on the client's right to chooses. Staff try, to weed out job applicants with paternalistic attitudes toward the elderly in order to preserve the program's mission of providing clients with what they feel they need, rather than with services a professional deems they need.

The I&A component of Senior Options is organized into four teams each comprising five I&A workers staffing the phones. When a call comes into to I&A the worker elicits from the caller what s/he is looking for, what the person's current health and functional status are, and the informal supports available. This screening call takes approximately 10-20 minutes. If long-term care services are needed, and the client needs more than a referral, the I&A staff person recommends either Basic, Ongoing, or Care Managed services. One of the features of the I&A component that program administrators thought crucial to the system's success is that each team is physically located in the same room, so that they can share information about resources and experiences with each other.

2. Role of Case Management in the Senior Options Program

While the demonstration phase of the program allowed for on site verification of the client's functioning and need for service either by a provider or a case manager, the current Senior Options program in Franklin County relies on a case manager to make this determination. That is, while an I&A worker may recommend Ongoing Services, a case manager makes a home visit to all persons recommended for Ongoing Services to determine two things: eligibility for services and whether the Ongoing Services or the Case Managed modality is more appropriate to the person's needs. As in the demonstration program, only clients in the Case Managed group receive traditional case management.

3. Client Profiles in the Senior Options Program

Approximately 64% of the Senior Options case load consists of clients receiving Ongoing Services, about 34% receiving Case Management, and only about 1% receiving Basic Services. According to reports from Senior Options administrators and

staff, the major distinguishing factor between clients in the Ongoing Services group and those receiving Case Management is the nature of the person's informal support network. Persons triaged into the Ongoing Services modality are either themselves capable of directing their own care, or have family or friends who can do this for them. Clients receiving Case Managed services, on the other hand, need assistance in this realm. While the majority of persons receiving Case Management have severe disabilities, many receiving Ongoing Services may be similarly disabled. Support, not functional status, seems to be the major determinant of which category of care that is most appropriate for a given individual.

4. Quality Issues in the Senior Options Program

As of June 1994 when the site visit was conducted, there were several quality assurance mechanisms in place, and the implementation of another was planned in the near future. First, monitoring of case managed clients occurs routinely with home visits and telephone contacts with clients. It is not the case managed clients who warrant concern in this program, but rather the clients who do not receive case management, particularly those receiving Ongoing Services who do not have routine contacts with a case manager. This responsibility falls to the I&A teams who monitor Ongoing Service clients by telephone every three months once services are initiated. Each I&A worker has approximately 100 Ongoing clients to monitor on a routine basis. Program administrators are currently considering re-designing this component of the program, as they have found that such frequent monitoring is not necessary for at least for a subset of Ongoing Assistance clients, i.e., those who can assume the role of advocate for themselves and may not need even minimal case management.

The Central Ohio AAA, which is responsible for overseeing the Case Management modality employs a Quality Assurance Coordinator whose major function is to act as a liaison to providers. This mechanism, however, tends to benefit the Case Managed clients, but not Ongoing Assistance--at least directly. A clinical manager is also on staff at the AAA who is available to provide assistance, direction and support to case managers; the clinical manager's activities may also be considered as part of the quality assurance endeavor. Additional quality assurance functions are performed by I&A supervisors who monitor calls and review triage decisions of I&A workers; one supervisor is assigned to each of the four I&A teams. At the time of the site visit there was an opening for a position dedicated to Quality Assurance for the Senior Options program at the Franklin County Office on Aging, but the position had not yet been filled, although it was expected to be filled in the near future.

Staff expressed concern about program clients who do not adopt a consumer approach to services. That is, they depicted many of the current elderly population as being reluctant to complain; they seem to embody the attitude of being thankful for whatever is given to them. There was concern that individuals with this approach to services who are receiving Ongoing Services may require case management monitoring to insure that they receive what they need. Staff also mentioned, however, what they are starting to see this attitude diminish in the elderly population and are seeing an

increase in consumer aggressiveness. It was also observed that when clients contribute to paying for the cost of their care, as is required of many program clients through a sliding fee scale, they seem to be less reluctant to voice concerns about problems they encounter with the provision of services.

D. Hamilton County Elderly Services Program

1. Overview

In November 1992 the citizens of Hamilton County Ohio, which includes the Cincinnati metropolitan area, voted in a property tax levy similar to that in Franklin County for the purpose of providing community-based long-term care to its citizens. $12 million became available for the Elderly Services Program (ESP) beginning in February 1993; by July key staff had been hired and enrollment was initiated in September. The program is administered by the Council on Aging of the Cincinnati Area, which also serves as the local Area Agency on Aging.

Hamilton County built upon the experience of both the state-funded demonstration and Franklin County's Senior Options Program in developing the ESP, but they designed their program with some unique features as well. Similar to the other two programs, ESP triages clients into three service categories: Basic (short-term), less intensive care management,[9] and intensive care management. Information & Assistance (I&A) also plays a large role in this system, serving as a single point of entry for all county residents age 60 and over seeking assistance with long-term care needs.

When the site visit was conducted in June 1994 the organization of ESP differed from the other two programs by virtue of having three separate functional units within the program: an I&A unit, an Assessment Unit, and a Care Management Unit. In general, the I&A unit operated, and still operates, very similarly to the other programs. In addition to fielding initial questions from callers, conveying to them the types of services available, and conducting an initial screening of client needs, the I&A workers also function as case managers to clients needing minimal services, i.e., transportation services only, home-delivered meals only, short-term services (Basic modality - less than 6 weeks duration).

Program administrators who were interviewed were emphatic that the ESP, particularly the I&A component, was designed “to listen to the needs of clients, not what a social worker thinks they need.” Yet while the ESP is based on self-report of need, clients are sometimes unclear about what they want or what their needs are. When I&A could not make a determination of the client's need (about 30% of the time), the client was referred to the Assessment Unit. Out of the approximately 100 I&A calls per week 35-40 were referred to the Assessment Unit.

[9] “Care” management, rather that “case” management, is used to describe the Hamilton County program because it is the term employed by the ESP program.

The major responsibility of the Assessment Unit was to conduct face-to-face in-home assessments for clients for whom I&A could not determine either the nature or level of need. Staff of the Assessment Unit also made home visits to all clients who were eligible to share in the cost of services; these home visits were to verify financial status and to explain to the client how the co-pay system operates. Assessment unit staff also conducted face-to-face assessments on all clients where there was a question of abuse or neglect. They did not carry a caseload and their activities with a given client were usually confined to a single visit. Upon completion of the face-to-face assessment the assessor developed a care plan and determined whether the client should be classified as needing intensive case management. Recently, however, the Assessment unit has been abolished, and its functions are now subsumed, within the Care Management Unit. A client is now assigned to a single care manager for all contacts--for a face-to-face assessment (if needed) as well as ongoing monitoring and other care management activities. This change was made in the interests of continuity of care.

Now, as before, not all clients receive face-to-face assessments. The majority of clients are assessed over the phone (by I&A) and services authorized and initiated without any face-to-face involvement of ESP staff. Client criteria that trigger a face-to face-assessment include: involvement of Adult Protective Services, age 90 or older, acute medical situation; not limited informal supports; or the need for services at or near the program maximum of $550 per month.

Eligibility for ESP services, besides being a resident of Hamilton County and age 60 or greater, a person must be unable to perform one or more ADLs or IADLs without assistance or have a behavioral or mental health problem that could result in premature institutionalization, or be unable to provide for his/her own health/safety due to a cognitive, behavioral, psychological/emotional condition.[10] Eight ADLs[11] and eight IADLs[12] are reviewed in the assessment process.

2. Role of Case Management in Elderly Services Program

All clients, except those receiving short- term Basic Services are assigned to a case manager. This feature of the program differs from the demonstration and the Franklin county programs where Ongoing Assistance clients did/do not receive care management. Until very recently ESP classified persons as needing Ongoing services or Care Managed services, very much like the other two programs. Then, a person was determined to need care management if s/he had an unstable medical condition, did not have an informal support system to provide the help needed, could not insure his/her own health/safety without oversight, or had formal service need that cost more than $350 per month (up to the program cap of $550 per month). That is, <u>all</u> clients with care cost exceeding $350 per month were automatically classified as needing intensive care

[10] Elderly Services Program Handbook, The Council on Aging of the Cincinnati Area, Inc.

[11] ADLs include: bathing/showering; walking/wheeling; transferring; eating; dressing/undressing; toileting; grooming; and continence.

[12] IADLs include: getting to places out of walking distance; handling personal business; shopping; doing housework; preparing meals; doing laundry; medication management; and using the telephone.

management. (Those clients with long-term care service needs but not prescribed intensive care management were classified as “Ongoing” clients, as in the other two programs.) Since the site visit in June, however, the triaging of clients into the alternative intensities of care management has changed. Currently clients are first classified into one of two categories based on the cost of the care plan, under $350, and over $350 (up to a maximum of $550) per month. Each client is assigned a care manager who determines within two months of program enrollment the level of care management intensity needed. Level I Care Management clients receive intensive care management, and are contacted 10 days after services initiation by the care manager, and every two months thereafter, and are reassessed at months 6 and 12. Event-based contacts and visits are conducted as warranted. Level II Care Management is less intensive. Clients are telephoned every three months, and an in-home visit is conducted at month 6; reassessments occur annually.

All care managers oversee the service provision of clients in both Level I and Level II Care Managed modalities. Historically, they have carried fairly large caseloads of about 230 clients. Recently, however, case loads have been reduced substantially to approximately 132 clients per care manager. This decrease in case load is due to the fact that ESP has hired more case managers to share the burden. Also, client enrollment has recently been capped and is growing at a slower rate. The enrollment rate is now tied to the disenrollment rate whereas in the past there were no restrictions on enrollments. Also as a function of the recent reorganization, all care managers now provide intensive case management for approximately the same number of clients--between 10 and 15, whereas in the past geographical location of clients was the major determinant of care manager assignments.

As mentioned previously, the I&A unit is responsible for monitoring clients receiving short-term Basic Assistance. Monitoring activities with this group of clients is minimal, given the truncated period during which they receive services, i.e., six weeks or less. Immediately following initiation of services an I&A staff person calls the client to make sure services are being delivered as intended. Another phone contact is made in the fifth week of service (or one week before services are scheduled to terminate, for persons authorized for less than six weeks of service) to confirm the date of service termination and to determine if there is a need to extend the authorization for services or to refer the client to the Care Management Unit for long-term service utilization.

3. Client Profiles in the Elderly Services Program

Current eligibility for Level I care management requires that a person must have at least one ADL deficit and lack an informal support system and meet one, of the following criteria: a recent change in a medical, emotional, or mental condition; a recent in change in life status (e.g., death of spouse); or inability to insure own health/safety. Before the recent reorganization all clients with care plans of $350 or more were automatically triaged into intensive care management. Reports from care managers that these clients did not necessarily need intensive care management and that the cost of

care plans did not always reflect a greater need for case management prompted a review of this policy.[13]

At the end of June 1994 when the site visit was conducted at ESP, the program was providing services to 3,678 clients, the vast majority of whom were being served in the Ongoing[14] modality (89%). Only one percent of the client base was receiving short-term Basic Services, and the remainder 10%) were receiving intensive Care Managed Services. Program administrators expect this distribution to continue under the reorganization.

The table below reports ESP client data as of June 29, 1994 by care management modality in affect at the time. In general, program clients were relatively young. Care Managed clients were the oldest, with about 26 percent age 85 or older. Compared to the nursing home population, for example, with approximately 40 percent in the 85 and over category, this group of long-term care users was fairly young. Regardless of service modality, the vast majority of ESP users were female, although the proportion of male clients was slightly higher in the intensive Care Managed modality.

The most striking difference in client characteristics as a function of the service modality was related to their respective disability levels. Most clients receiving Basic or Ongoing services were moderately impaired, all with at least some IADL disability, and a large proportion with 2 or fewer ADL dependencies. These two groups contrast sharply with the Care Managed group which was substantially impaired; over half of Care Managed clients reported 3 or more ADL disabilities. Although the extent of informal supports available to the client was noted as a key criteria for identifying appropriate candidates for the Care Managed modality, comparable statistics on the support network were not available during the site visit, and therefore are not reported here.

TABLE 1. ESP Client Profiles by Service Modality: June 29, 1994

Client Characteristic	Basic	Ongoing	Care Managed
% < Age 85	86.9	79.3	73.7
% ≥ Age 85	13.1	20.7	26.3
% Female	75.0	76.5	71.9
% Male	25.0	23.5	28.1
% 1+ IADLs/8	100.0	100.0	100.0
% No ADLs/8	39.3	35.2	17.1
% 1 ADL/8	26.2	22.5	11.9
% 2 ADL/8	7.1	15.1	16.8
% 3+ ADL/8	27.4	27.3	54.2
N	84	4,235	537

SOURCE: Council on Aging of Cincinnati, ESP Client Demographic Report

[13] High cost care plans were sometimes a function of the type of services authorized, e.g. adult day care, rather than client need for case management.

[14] Comparable to less intensive, minimal care management.

4. Quality Issues in the Elderly Services Program

The ESP relies on feedback from providers and random audits by the Quality Assurance Department for insuring the provision of quality care to its clients. Particularly since the ESP conducts most initial assessments over the phone, there is a great reliance on providers to report back to the intake workers or care managers when they discover situations to be different than reported by the client over the phone. When these situations arise, a care manager is usually dispatched to the client's home to conduct a face-to-face assessment. In addition to provider feedback, the program's Quality Assurance Department conducts random audits of three percent of clients. These audits include a visit to the provider agency to review client records, as well as a home visit to the client. The Quality Assurance Department is also proactive in identifying patterns of complaints from clients, e.g. with a certain provider, and investigating these complaints.

E. Summary

Perhaps the two features that all three of these Ohio programs share, and which are noteworthy in their divergence from traditional models of case management, are: 1) emphasis on client self determination; and 2) rationing of intensive case management to a relatively small proportion of clients.

While it was clear from interviews with staff in both of the current programs that rationing case management is related to managing program costs, the structure of the intake and care planning processes are not driven by cost containment, but rather reflect a fundamental commitment to client autonomy. Clients are asked what they need and want, in light of the array of services available in each program. Clients, once they know what is available to them, are ultimately responsible for shaping their care plans. Clients are also expected to take an active role in monitoring the care that they receive, particularly those not triaged into the intensive case management modality. As staff noted, there are some liabilities associated with this approach, especially with the current cohort of the elderly who are unaccustomed to questioning health care providers or to complaining about services being provided at little or no cost to them. But staff did feel this proclivity of the current elderly is slowly changing with evidence of a future generation of elderly becoming more outspoken about unsatisfactory care.

III. AGING AND ADULT SERVICES ADMINISTRATION, STATE OF WASHINGTON

A. Overview

The Aging and Adult Services Administration (AASA) of Washington's Department of Social and Health Services contracts with 12 of 13 local Area Agencies on Aging (AAA) across the state to perform case management functions for its state-funded and COPES (Community Options Program Entry System, Washington's Medicaid Home and Community-Based Services waiver for the elderly) programs for the elderly.[15] How the state of Washington delivers case management services to its elderly population is notable in two respects. First, it has implemented a two-tiered approach: a) Information and Referral (Senior I&A); and a) Case Management. Second, achieving stability of the client's situation in a relatively short amount of time is a goal towards which case managers are expected to actively work so that clients can be discharged from case management as soon as possible. With the exception of some special populations, most case managed clients are discharged from case management within several months of admission to the program. The exception to the "stabilize and discharge" rule are COPES clients for whom ongoing case management is required.[16] In this regard, the state is currently planning to submit a Medicaid state plan amendment that will seek to re-classify case management as an optional waiver service.

The I&A component serves all elderly (aged 60+) contacting an AAA for any type of information or assistance. Social workers staff the I&A component and conduct informal screenings, usually over the phone, to determine the potential client's needs. At this juncture the I&A worker tries to identify whether the individual needs service referral, assistance/advocacy in gaining access to a service, or whether s/he is a potential client for case management. If the need for case management is a possibility, the client is referred for a comprehensive assessment to determine whether needs are sufficiently complex to require case management.

B. Case Management Triage Criteria

Guidelines for referral to ongoing case management for the 60+ population include the need for multiple services and the inability to obtain the required services

[15] Similar programs for the 18-59 year old population are not only administered under the auspices AASA, but are also managed by this group. Case managers for the under age 60 population are state employees of the AASA. Also within the purview of AASA case managers are the 18-59 population in need of an Adult Protective Services investigation, as well as nursing home residents who require assistance in relocating outside the nursing facility to a lower level of care.

[16] Monthly case management contacts are required for participants in the COPES program.

and inability/unwillingness of informal supports to provide the assistance needed. The multiple needs criteria is not necessarily based solely on ADL or IADL needs, but may include the need for medical insurance or assistance in applying for Medicaid as well.

C. Criteria for Terminating Case Management

While there are no stringent criteria for determining when case management should be terminated, the overarching principle followed by case managers is to discharge when the case is stabilized. Operationally, stability is achieved when the care plan has been implemented and is functioning in a stable fashion.

Stability in this context does not necessarily refer to medical stability, but rather to services being in place and all case management goals developed as part of a care plan having been met. One case manager characterized the elements of stability to include a consistent, quality in-home care provider (formal provider) and/or a reliable informal caregiver. In this regard, several case managers interviewed cited difficulties in stabilizing care plans for clients relying on independent providers (IP), as they find more inherent instability in the client-IP relationship than when agencies provide the in-home workers. They point to the built-in mechanism of oversight in the agency model, absent in the IP model, as an important element in achieving stability.

D. Duration of Case Management Services

The AASA has not established any regulations or guidelines for the optimal duration of time for which clients should receive case management. However, in interviewing case managers from four different agencies in the Seattle metropolitan area, there was a range in estimates of average amount of time that clients who received case management were on the service. The shortest estimate was three months from the Pierce County AAA in the Tacoma area; three months is a target toward which the agency urges case managers to actively work. Two other agencies (Seattle/King County Division on Aging, Evergreen Care Network--a subcontractor to the Seattle/King County Division on Aging) cited an average of six to seven months duration, and argued that a three month time frame was too short and would increase the chances of terminated clients cycling back into the system because they had been discharged prematurely before true stability had been achieved.

There was overwhelming acknowledgement, however, among all the case managers interviewed that certain clients require ongoing case management indefinitely, due either to the characteristics of the clients themselves and/or their families/informal caregivers. In the following section, the circumstances under which case managers see the need for continuing case management are discussed in further detail.

One additional note about the duration of case management: during the interviewing process, case managers were asked to estimate the average duration of case management services for COPES clients if and when case management were to become an optional service for this population. Case managers predicted that COPES clients would be on case management a bit longer than state-funded clients--on average 10 months, perhaps--as a function of their heightened frailty level as compared to the state-funded clients.

E. Clients Who Are Difficult to Terminate

Although none of the case managers interviewed, nor their administrators, questioned the reasonableness of rationing case management or of limiting the duration of the service, all expressed reservations about terminating case management for certain types of clients. There was a difference of opinion surrounding the client's physical condition. Some believe that clients with a chronic or unstable medical condition required ongoing case management indefinitely, while others dismissed this as a criterion upon which they based their termination decisions. All were in agreement, however, that clients or caregivers with untreated severe mental illness were difficult to terminate because of the problems that often arise in relationships with providers. For example, several case managers spoke of situations where clients/caregivers were verbally or physically abusive to in- home workers; it is difficult to stabilize a care plane under such circumstances.

Another factor, often related to mental health issues as well, that complicates the decision to terminate is the poor judgement of clients or behaviors which result in encounters with the criminal justice system. These individuals are often resistant to, and non-compliant with, medical regimens prescribed for their psychiatric conditions. Also mentioned as situations where it is difficult to remove case management is in rural areas where services are not as readily and consistently available; when there is abuse in the home either by, or directed toward, the client; where informal care is minimal or dysfunctional; and where substance abuse is involved in the client/caregiver constellation.

A group of clients for whom there may be a special need for continued case management are those who do not speak English, and who do not have family/friends who speak English. The needs of this group were poignantly presented during a group interview of approximately 15 case managers from the Asian Counseling and Referral Services (ACRS) in Seattle. The ACRS, operates under contract with the Seattle/King County Division on Aging. The ACRS has on staff personnel who speak 13 different Asian/Pacific Islander languages and serves a population with very diverse cultural backgrounds who experience substantial problems in accessing health and social services due both to language and cultural barriers. The job of the case manager in the ACRS is to straddle the two very different worlds of East and West, and to assist clients in traversing mainstream western resources as well as tapping into the ethnic resources available in the community.

Through anecdotal accounts relayed during the interview these case managers spoke of the difficulties in terminating their clients from case management, except upon death or institutionalization. This is because the case manager becomes the client and family's link to the English-speaking world. Family members don't usually speak English, and case managers try to arrange for in-home providers who speak the client's native language; thus, neither client, family, nor provider speak English. The only person left to negotiate the English-speaking world of health care workers and government bureaucracies is the case manager. Moreover, many of the clients at the ACRS speak languages for which there are very few translators in hospitals, clinics, or government agencies. For example, there are 89 Filipino dialects alone. While some case managers in other locations in the state said that the client's medical conditions and its stability/instability were not usually factors that contribute to delay in termination from case management, the ACRS case managers stated that a medically unstable client needing frequent hospitalizations or interactions with medical providers required a substantial amount of case management involvement due to language barriers.

F. Quality Issues

It appears that one motivating factor behind the limits placed on case management services in the state of Washington is the associated cost. The other is to prevent clients from becoming overly dependent on case managers, and thus compromising client autonomy. Regardless of the merits associated with these reasons, some case managers raised concerns about quality assurance in the absence of ongoing case management. Once a case is closed to case management, it is incumbent on the client and the family to report back to the agency if the client's needs change or if there is a problem with a provider. An administrator from the state's AASA commented that when a case is closed it is supposed to be referred back to I&A for periodic monitoring, but it is unclear to what extent this practice is realized across the state. One administrator interviewed (Evergreen Care Network) mentioned that her agency relies on volunteers to monitor cases closed to case management for one to six months following termination, and that volunteers have access to a “closure sheet” which indicates what needs monitoring. The same agency also conducts quarterly client satisfaction questionnaires directed to all clients closed to case management during the quarter; if any problems are detected clients are recontacted by the agency. As mentioned previously, case managers perceive situations where independent providers are involved as potentially more problematic in terms of monitoring since no agency oversight is involved.

Overall, there seems to be virtually no mandated quality assurance activities by a third party for persons receiving home services under the state-funded program but discharged from case management. The only opportunity for an objective assessment of quality of care for this group of care recipients comes during the mandated periodic assessments conducted 30 and 60 days after the initial assessment, and then again on the one year anniversary of the initial assessment. However, this predicament is not

true for COPES clients nor for Medicaid clients receiving personal care services where a built-in quality assurance mechanism has been mandated by requiring periodic in-home visits by a nurse monitor (as well as a monthly case management contact for COPES clients).

G. Local Alternative Approaches to Case Management

Alternative approaches to the delivery of case management services and its various components have sprung up in local agencies within the state. From the limited number of agency interviews conducted in the Seattle area a couple of variations surfaced. For example, the Seattle/King County Department on Aging utilizes college work-study students as case aides to ease the burden of case managers in activities such as assisting clients in filling out Medicaid applications, seeking housing alternatives, arranging for doctor's appointments, etc. The agency views the use of case aides as a cost-effective approach to accomplishing some of the necessary, but routine, activities of case management.

The same agency has also instituted a relatively new component to its case management repertoire: Intensive Case Monitoring. Two case managers have been assigned to the Intensive Case Management division and each works in conjunction with regular case managers on identified clients who need additional attention. Clients identified for intensive case management often include those who need, but are unwilling to access, mental health services and those who get involved with the criminal justice system due to behavior control problems. Typical triggers for intensive case management are resistance to care, particularly mental health services, hoarding type behaviors i.e., cars, home is cluttered to the point of danger due to fire hazard, etc. Intensive Case Management allows more contact with difficult clients so that progress can be made in actually implementing and stabilizing a care plan to the point where the intensity of case management activities can be decreased, or case management can be terminated, or terminated sooner than would occur without the intensive case management.

H. Summary

The state of Washington's state-funded home care program offers a unique opportunity to view the application of case management in a system that tries to operationalize the principle “stabilize and terminate”. While most case managers view this as a reasonable maxim, there is a range of opinion on the optimal duration of case management services (3-7 months), but there is also a fair amount of agreement about the types of clients who require more than the average time on case management service (clients with mental health/substance abuse problems). In addition, clients whose culture and language differ from the mainstream are also more needy of case management services due to the difficulties such individuals have in dealing with the mainstream medical establishment and government bureaucracies. Another theme

emerging from interviews with the case managers was the absence of a strong quality assurance mechanism for the state-funded home care clients once discharged from case management. Unlike Medicaid clients receiving personal care services or those on the home and community-based services waiver program (COPES), who have an ongoing case manager or who are monitored by nurse oversight, state funded clients go without much oversight once they are discharged from case management. Although case managers seemed to have authentic concern about not inducing dependency in their clients, they also seemed truly concerned about the deficiency in oversight for discharged clients.

IV. HOME CARE PROGRAM FOR ELDERS, STATE OF CONNECTICUT

A. Overview

Connecticut's Home Care Program for Elders has a dual funding stream--Medicaid dollars targeted to disabled elders meeting eligibility requirements (financial and health/functional) for the state's Medicaid home and community based waiver program and state funds targeted to disabled elders not eligible for the waiver program. Until 1992 these two programs were administered by separate government agencies--the waiver program by the Department of Income Maintenance, and the state funded program by the Department on Aging. At that time these programs were consolidated as part of a state reorganization plan; currently both programs are administered by the Alternate Care Unit of the Department of Social Services (DSS), the new department formed by combining the Departments of Income Maintenance and Aging & Human Resources.

Historically, the state-funded home care program contracted with Connecticut Community Care, Inc. (CCCI), a private non-profit agency, for case management services. The case management model employed was typical of many case management agencies and included assessment, care planning, service arrangement/referral, service monitoring and reassessment. CCCI is regarded as one of the premier case management organizations in the county with a highly educated and trained case management staff. When the state developed its waiver program for the elderly during the late 1980's it modeled the case management component of the program after the state-funded program, requiring independent case management as integral to the waiver service package.

Shortly before the state reorganized its departmental structure, the Commissioner of the Department on Aging issued an RFP calling for a demonstration of provider-directed case management. The apparent motivation for the demonstration was the high cost of case management which, it was argued, could be reduced if providers (i.e., home health agencies) assumed the role of case manager, and could bill Medicare for at least a portion of their case management activities. There seems to have been a strong lobbying effort by some in the provider community for an opportunity to assume the case manager role and functions. A one year contract was let to the Connecticut Home Care Coalition, a coalition of six certified home health agencies (HHA) whereby the HHA would assume case management responsibility for state-funded clients identified as being appropriate for the demonstration. Demonstration eligibility criteria were two-fold: 1) functional and financial criteria applied to the state-

funded program[17] and 2) home health service need and the need for no more than two additional community services.

During the course of the one-year demonstration the departmental reorganizations occurred resulting in the combining of the state-funded an d Medicaid waiver clients under the management of the Alternate Care Unit. Due to a projected future funding shortfall resulting from the merging of the two departments, the Connecticut Home Care Coalition was directed to close intake on new demonstration clients as of June 1992. Before the Department of Income maintenance was subsumed into the newly formed Department of Social Services, it had begun a parallel process of developing a similar, yet somewhat different, approach. Consequently, in February 1993 the newly formed DSS initiated the Self-Directed Care (SDC) component as part of its Home Care Program for Elders, where a role for providers collaborating with clients and families on care management was created.

B. Self-Directed Care

According to the Procedures and Guidelines for Self Directed Care, the self directed care (SDC) model "assumes that there are situations in which the client and/or family can work directly with provider agencies to effectively coordinate and monitor the client's care, without the assistance of an independent case manager."[18] Prior to the SDC program, it was assumed that all elderly state program clients needed case management. Under the new guidelines, however, the state requires that case management be treated like all other services in the continuum of care--"that case management should be prescribed, rather than assumed..."[19]

Unlike the criteria used in the provider-directed care (PDC) demonstration where the criteria for deciding which program-eligible clients should be considered for PDC was based on the number and type of community services needed by the client (i.e., home health plus no more than two additional services), the criteria for deciding appropriateness for SDC focuses on the client's (or client's family's) ability to manage and monitor their own services with the assistance of a provider.

[17] These criteria varied depending upon when the client entered the state-funded program. New clients during the demonstration year were required to have a severe need for long-term care services and be at immediate risk (within 30 days) of hospital or nursing home admission if home care services not provided and have one of the following: 2+/5 ADL needs, or 4+ MSQ errors accompanied by behavior problems requiring daily supervision, or a critical unmet need for assistance with proscribed medications. Clients transferred from CCCI to the coalition may not have met the above criteria because they had been admitted to the PIL at a time when eligibility criteria were less stringent, and in effect had been grandfathered into the ongoing state-funded program.

[18] Connecticut Home Care Program For Elders, Department of Social Services, Procedures An Guidelines for Self Directed Care, January 1993, p1.

[19] Ibid.

C. Case Management Triage Criteria

The need for case management as a long-term care service is reviewed at multiple points during a client's tenure in the program. All clients deemed eligible for either the state-funded or waiver program (based on their financial and functional/cognitive/behavioral/support profiles[20]) undergo a comprehensive assessment conducted by a case manager from the Coordination, Assessment and Monitoring (CAM) agency.[21] This assessment becomes the basis upon which the case manager develops a care plan. As part of the care planning process, the case manager completes a "Checklist to Authorize Case Management". This checklist, completed by the CAM case manager, specifies the conditions under which self-directed care is generally considered inappropriate:

- Client does not have a stable and appropriate living situation (considered temporary condition that necessitates case management)
- Client is not obtaining appropriate health and medical care (considered temporary condition that necessitates case management)
- Activities related to client obtaining social and/or economic resources/benefits are in process (considered temporary reason that necessitates case management)
- Client exhibits behavior problems (Abusive/assaultive, wandering; unsafe/unhealthy hygiene or habits; threats to health/safety)
- Client has an MSQ score of 4+ errors and no informal caregivers available, willing and able to manage care
- Continuation of care by informal caregivers depends on active intervention by case manager
- Functional and/or cognitive status have changed in a way that require care plan changes in the past 2 months or are expected to occur in the next 2 months

If the client's profile/situation matches none of the above criteria, the case manager is given the opportunity to identify and specify other factors that should

[20] Current (minimum) functional eligibility criteria for the state-funded program are:

- 1+ critical needs (bathing, dressing, toileting, transferring, eating/feeding, meal preparation, medication management); or
- Behavior problem plus 4+ MSQ errors plus a need for frequent supervision due to behavior problems

Current eligibility criteria for the Medicaid home and community based services waiver program are:

- Willing to consider nursing home placement; and
- 3+critical needs (see above); or
- Behavior problem plus 4+ MSQ errors plus a need for daily supervision due to behavior problems

[21] Currently there is only one licensed CAM in the state--Connecticut Community Care, Inc. (CCCI).

preclude SDC. If SDC is deemed inappropriate, the case manager is asked to project a date, if possible, when SDC should be reconsidered.

It is unusual for new clients to by-pass case management, at least for their first 60 days on the program. While it is possible for new clients to be self-directed, case managers are reluctant to recommend SDC initially as they feel that it takes a couple of months to get to know a client and his/her family and to get an authentic read on the client's needs and how the informal care network actually functions. This perspective is reflected in the SDC procedures and guidelines manual which states that “authorization for case management is assumed for the majority of now clients for their first 60 days...”

When SDC is first authorized for a client, the client is sent a notice informing him/her of what SDC is, and how to contact the “lead” provider agency for assistance if a change in the care plan is needed. Also included in the notification is a DSS contact person in the event the client cannot reach the service provider and/or client is dissatisfied with the provider's response to the his/her request.

If case management is authorized as part of the initial care plan, the CAM must review the need for this service at the first two 60-day reviews. This is an internal CAM procedure; only if SDC is recommended does the CAM contact the DSS for approval of the change from case managed care to SDC. The same procedure occurs at 6 months following program entry, but at this juncture DSS does review the checklist to authorize case management. If case management continues, the appropriateness of case management is reviewed again at the time of the individual's annual reassessment.

Current clients are reviewed for the appropriateness of case management during their annual reassessments. If they are deemed appropriate for SDC by the case manager, and it is authorized by DSS, then the client and/or family manage the client's care and work directly with providers. When changes occur in the client's status, regardless of whether the client is new or ongoing, the “lead” provider is responsible for implementing the changes within guidelines set by DSS. Also, all SDC clients must have their plans of care reauthorized every six months by DSS, including a review of the continued appropriateness of SDC. Annual reassessments for SDC clients are conducted by the “lead” provider agency.

D. Role of Providers in Self-Directed Care

Connecticut's operationalization of the SDC concept is based on the assumption that at least one service provider is involved in providing home and community-based services to the SDC client. When only one provider is involved in the client's plan of care, DSS contacts this agency to alert them to the fact that the agency and DSS will be responsible, along with the client, for insuring continuity of care. When more than one agency is involved in the plan of care, DSS identifies a “lead” agency which is expected to assume the coordination role. DSS's order of preference in identifying the lead provider is first, a home health agency, and second, an adult day care provider. If

neither type of provider is involved, then DSS regional office staff assume the coordination role.

The lead agency's responsibilities include making changes in the client's care plan, as needed. Depending on the nature of the change required, the lead agency may have to seek prior approval from DSS. Also included in their responsibilities are completing plan of care reauthorization forms every six months and annual reassessments. Lead agencies are not reimbursed separately for ongoing case coordination, but are reimbursed for conducting annual reassessments. There are, however, regions within the state where there are few providers willing to assume the lead agency responsibility. In these instances the DSS regional staff must assume the coordination role.

E. Profiles of Self-Directed Care Clients

Between February 1993 and June 15, 1994, 273 clients had been served as SDC clients in the Home Care Program for Elders. (This number includes 147 individuals who were grandfathered into SDC as a result of participating in the PDC demonstration.) As of June 15, 1994 there were 198 active SDC clients. This represents less than one percent of all currently enrolled program clients. Of all the SDC clients served at any point between 2/93 and 6/15/93, 65 (23%) were discharged from SDC. Fourteen of those discharged returned to case managed care. The remainder of those discharged either had all services discontinued (9), moved out of state (4), were admitted to a nursing facility (3), were hospitalized in a state psychiatric facility (1), or died (13).

Currently no analyses have been conducted on the SDC group that either describe the profiles of these clients, or how they may differ from case managed clients. However, the quality assurance director at CM is currently in the process of assembling results from a review of all clients recommended for SDC. While these data have not yet been tabulated in a form to report a statistical profile of the group, the CCCI's QA director has reviewed each client's record and summarized her impression of the client types most likely to be SDC:

- Persons living alone and receiving a relatively low level of service

- Persons living with someone, receiving a modest amount to a lot of services, health condition is stable, and the informal caregiver(s) is very comfortable interacting with providers[22]

These impressions were confirmed by case managers as well as providers who were interviewed as part of this study. Case managers and providers also pointed out that it is not the level of need or disability of the client that determines their

[22] Personal communication with Myra Kerr, Director of Quality Assurance, Connecticut Community Care, Inc. on June 21, 1994.

appropriateness for SDC, but rather the client's or the informal caregiver's ability to coordinate the client's care and their level of comfort in dealing with providers. In fact, it was pointed out that some individuals with very few services are often the types of clients that need intensive case management because of their reluctance to accept services and be compliant with medical regimens, thus placing them at risk of exacerbations and hospitalization without vigilant oversight by the case manager.

F. Challenges to Implementing SDC in Connecticut

Perhaps the most challenging obstacle DSS has encountered in implementing SDC has been the historical tensions between the provider community, most notably the home health agencies and CCCI, the state-wide case management agency. As noted above, a segment of the home health provider community has been a very strong advocate for provider case management, affecting to some degree at least the state's decision to conduct a demonstration of PDC.

These providers feel that home health nurses are competent to provide case management, that they already do this and are reimbursed by Medicare for this function. Moreover, they argue that since case management is now considered a service like any other service in the care plan, a CAM (CCCI) should no longer be considered an “independent” agency eligible for developing care plans, since they have an unfair advantage in being able to recommend their own services (i.e., case management) as part of the care plan. These home health providers perceive the situation as unfair because they are not allowed to be reimbursed for case management (by the state), nor are they allowed to develop care plans (except in the case of referred SDC clients) because they are not considered an “independent” case management agency. The argument is also made that clients tend to rely on the home health providers when they encounter problems, rather than the independent case manager because it is the home health personnel with whom they have the most direct and consistent contact.

DSS's response the latter issue is that DSS, not CCCI, makes the final determination whether a client is appropriate for case managed care or SDC via their review of care plans and the checklist to authorize case management. The former issue is one for which there is wider debate in the long- term care arena. In general, the debate centers around whether home health can provide the comprehensive case management typically offered by case management agencies. The concern remains that given the financial incentives of home health providers to focus on the client's medical needs, case management in the home health environment reverts to case management of medical conditions, and does not attend to the broader social needs of the client.

Another challenge that leadership at the Alternate Care Unit has faced is educating their own staff and CCCI about SDC. This challenge should not be underestimated. A paradigm shift has occurred at the policy level; yet, for it to be

implemented there will probably have to be a considerable amount of education, persuasion, and change in the usual and assumed relationships between the regional DSS staff and case managers. While CCCI leadership acknowledges the appropriateness of some clients to self-direct, there is still a good deal of reluctance on the part of front line case managers to discharging their current caseload to SDC. This reluctance seems to emanate from their perception that either clients would be negatively impacted by removal of the case management benefit, or that clients and their informal caregivers have become accustomed to and/or emotionally dependent on their case manager and do not want to give up this service--even though it may not be necessary. Case managers are also reluctant to recommend SDC for a new client, arguing that case management is necessary for at least a few months in order to get to know the client sufficiently in order to develop the most appropriate care plan and to determine if they are good candidates for SDC.

In addition to the reluctance of case managers to recommend SDC, there is the further complication of the relationship of the DSS regional office staff to the case managers. From its inception, the waiver program was designed such that state-employed regional staff, i.e., those who review and sign-off on assessments and care plans developed by case managers, are collocated with CCCI case managers. Historically the proximity of DSS regional staff to the case managers has been regarded very positively by both the state and CCCI. However, with the introduction of the new case management paradigm, the collocation factor has presented additional challenges. Having worked in such close proximity, DSS regional staff and CCCI case managers have developed relatively close working relationships and, in general, positive regard for each other, both personally and professionally. Yet with the paradigm shift coming at the insistence of the state, DSS regional staff are now expected to challenge the case management/SDC determination s of the case managers; at times, this expectation places them in an adversarial position vis-a-vis their case manager colleagues, literally down the hall from them. Whereas in the past, regional staff would most often defer to the professional judgement of case managers regarding service plan needs, they are now in the position of having to challenge their assessments of need (for case management). Regional DSS staff, in essence are being called upon to become change agents--not always the most comfortable of positions.

DSS's central office has recognized this situation and has initiated additional support and training sessions for both regional staff and case managers around the identification of candidates for SDC. A major goal of these sessions is to increase the comfort level of both case managers and regional DSS staff in recommending SDC by outlining the programmatic mechanisms for insuring that SDC clients have adequate avenues for addressing their needs and complaints. These sessions also include discussion of the process for terminating long-term clients from case management, and provide case managers with the support and permission to “let go” of their long-standing clients when SDC is the more appropriate option. DSS reports that there is some early evidence that these meetings are having the intended effect of increasing the number of SDC clients, i.e., between mid- June 1994 and October 31, 1994 the program saw a 25 percent increase in the number of current SDC clients.

While the burden of implementing the paradigm shift rests heavily on DSS regional staff, they are increasingly facing yet another burden, also an outgrowth of the SDC policy. As mentioned earlier, not all providers are willing to assume the role of lead provider. When no lead provider can be identified, DSS regional staff must assume the responsibilities that otherwise would have been accepted by the lead provider. These responsibilities include being the point of contact for clients experiencing any difficulty with providers or needing a change in a care plan. DSS staff must also conduct routinely scheduled assessments and review of care plans for these SDC clients. Thus, regional staff, especially in areas where providers are reluctant to become lead providers, assume additional responsibilities. Regional personnel voiced concern that as the number of SDC clients increase, the resulting additional responsibilities on current staff would quickly exceed capacity. While regional staff seem to be supportive of the concept of SDC, the additional responsibilities combined with the unpleasant task of having to second guess their case manager colleagues, may produce an incentive to authorize case management when SDC might be more appropriate.

After 20 months following implementation (October 31, 1994) DSS reported that 249 clients were currently enrolled in SDC. While this represents a 25 percent increase over four and one-half months previous (June 15, 1994), the percentage of clients in SDC is still very low--about four percent. The reluctance of case managers and regional staff alike presumably has contributed to the relatively slow SDC enrollment, as well as some administrative billing issues necessitating provider bills from SDC clients be paid by the CAM. At the present time these billing issues have been resolved. Also, DSS has recently completed a series of training sessions with their regional staff and the case management offices, and is optimistic that both of these factors will result in increases in the SDC client population. However, if SDC is to increase to 20% of program participants, which DSS sees as appropriate, the Department will have to address both its own internal capacity in the regional offices for assuming the increasing work load that SDC generates, as well as the reluctance of some providers to take on case management activities. These two factors are intimately related as the work load of regional staff is increasing in areas where providers refuse to assume the “lead provider” designation.

V. DIVISION OF SENIOR AND DISABLED SERVICES, STATE OF OREGON

A. Overview

Oregon has received much attention for its innovative approach to providing options for the elderly and disabled in need of long-term care services. Over the last two decades Oregon has established a menu of alternative home and community-based care services to serve this population including In-home Services (both agency providers and independent providers), Assisted Living, Adult Foster Care, Residential Care, and Specialized Living Facilities (particularly for those with spinal cord and head injury). Oregon has achieved recognition for utilizing Medicaid waiver dollars not only to assist persons in the community who are nursing home eligible to remain in the community, but also to relocate nursing home residents to less restrictive environments. Because there is often no viable community living arrangement for the institutionalized person to return to, the state has worked with local governments and individuals to develop a network of Adult Foster Care residences statewide. Adult Foster Care has been especially successful in the more rural areas of the state where there is less investment in, and development of, other types of communal residential facilities such as residential care homes and assisted living facilities. As testament to the state's commitment to offering the disabled options in living situations and types of providers in a community setting, over the last ten years there has been a documented increase in the numbers of elderly and disabled receiving care in the community with no comparable increase in the number of nursing home residents. In fact, the state has witnessed a decrease in the number of nursing facilities over the same time period, despite a growing aging and disabled population.

The long-term care service delivery system is very localized in Oregon, with a single point of entry of all persons in a given geographic area designed to encourage access. In some regions the local Area Agency on Aging serves as the single access point, and in others the responsibility is shared between the AAA and the state Multiple Service Office. Regardless of the organizational structure, there is a single telephone access number for the public to call.

One of the guiding principles, stated in the original enabling legislation that created the Division of Senior and Disabled Services (DSDS), and which commissioned this department to develop and expand community options for the disabled, is that the elderly should “receive the necessary care and services at the least cost and in the least confining situation.”[23] A related corollary of this principle is that the state should provide services for the elderly and disabled

[23] Senate Bill 944 of the 1981 Session; ORS 410.

> ...through programs and in settings which maximize their ability to function as independently as possible and which encourage the principles of personal dignity, individuality, privacy, the right to make choices, and the right to a decent quality of life.[24]

B. The Role of Case Management

One of the essential elements in DSDS's program for the elderly and disabled viewed as integral in achieving these principles, is case management. All individuals seeking and/or receiving any government-funded long-term care services in Oregon receive case management--regardless of the funding source. Persons residing in the community as well as those in the nursing home are assigned a case manager whose ultimate responsibility is to see that the person gains access to the services required to maintain him/her in the least restrictive setting as possible, in a cost-effective manner.

It should be noted that even persons who receive assistance from non-agency independent providers, called Client-Employed Providers (CEP) in Oregon, receive on-going case management. Although the client is responsible for hiring and supervising the provider, and must certify to the state that services were rendered as authorized each month, a case manager still monitors the care provided by the CEP.

C. Client Profiles and the Intensity of Case Management

The reason that Oregon was included as a case study for this report on the rationing of case management is because its organization of case management recognizes that the intensity of case management need varies by client. While reassessments are required every six months, case managers re allowed to specify how soon after an initial assessment or re-assessment a monitoring contact should occur. This flexibility provided to case managers is supposed to parallel the case manager's assessment of how intensively the client needs to be followed. In reality, case managers reported that although they appreciated this flexibility they often specified the need for more (rather than less) frequent contact due the paper work that would be necessary to justify a contact before the specified time period had elapsed.

Regardless of how monitoring flexibility is implemented, the case managers interviewed were able to offer numerous examples of the types of clients that require more intensive case management. They include persons who are non-compliant with medical regimens and who, as a consequence, pace themselves at risk; those with dual psychiatric diagnoses; those with impaired brain functioning (this includes not only the elderly but AIDS and MS clients with brain involvement) that effects capacity to make good judgements; those who mismanage their medications; those with more numerous and severe disabilities, and those living in households in which there is substance abuse. Also mentioned were clients whom case managers perceived as having poor

[24] The Division of Senior and Disabled Services' philosophy statement.

judgement in the kind of person they hired a s their CEP, i.e., CEPs with substance abuse problems, CEPs who are abusive, etc. They also spoke of clients with personality disorders or other mental illnesses who often encounter difficulties in their relationships with their CEPs, resulting in the CEP resigning; these situations then can escalate into crisis situations where there is no immediate provider, thus generating additional work for case managers who must assist the client in locating a replacement.

Clients with HIV who are program participants often require more intensive case management since they come onto the program in the later stages of their disease when their needs are accelerating quickly; many need their care plans to be adjusted frequently to keep pace with their increasing needs. Another group to which case managers pointed that frequently requires more intensive attention from case managers are the head injured population. This population often needs more assistance from case managers for the first several years after they become disabled, i.e., assisting them in managing their caregivers/providers, teaching them about their conditions, etc. It was also pointed out that the younger disabled population, including the brain injured, tend as a group to be risk takers, with the recipitating incident associated with their disability often the result of poor judgement and inordinate risk taking; this personality type often continues to engage in risky behaviors and make poor decisions after they have become disabled, resulting in situations that require more intensive involvement from the case manager.

Another group that case managers identified as needing more intensive case management is probably somewhat unique to Oregon and is a function of the aggressive stand the state has taken on maintaining the elderly and disabled in the least restrictive setting as possible, preferably in the community. That is, case managers expend considerable time and energy relocating clients to more appropriate settings, i.e., when a person moves from their own home to a foster care home, when someone leaves a nursing home and moves into a foster home, or even a move between foster homes for a given individual.

Case managers also identified clients from certain ethnic groups which require more of their attention. These are groups which have not been well assimilated into our society. Three groups were highlighted: the Gypsy population, Russian immigrants, and the Asian population. Case managers find difficult and time consuming in working with the Gypsy and Russian populations as they have to work more diligently to assess the client's social, medical and financial situations. Case managers said that because deception is part of the Gypsy mores, it is frequently difficult to obtain a valid assessment of the client's situation, and subsequently to develop a care plan that addresses true needs. Case managers also reported that in both the Gypsy and Russian immigrant populations there is a tendency to view the government as a legitimate source of income. It is sometimes difficult for immigrants from the former USSR who lived in a welfare state to understand, as one case manager described it, “that the program is not a financial aid system.” Case managers also encounter the misuse of CEP funds from these populations; clients certify that they have received

services from their CEP, often a relative, when in fact the money was merely handed over without much service being provided, leaving clients without needed services.

Case managers reported that very much the opposite types of situations develop with members of the Asian community. Asian cultures tend to pride themselves on their self-sufficiency, and consequently are reluctant to acknowledge their dependency needs, particularly to case managers who tend to be non-Asian, Case managers serving this population reported that they tend to spend more time tying to understand Asian clients' needs, and convincing them to accept the services that they need. There was also general recognition that language as well as cultural barriers add to the amount of time case managers must spend with non-English speaking clients and families.

D. Summary

Case management as applied in Oregon's DSDS programs in many ways fully embodies the traditional model of case management where the case manager is involved with a broad array of clients through all phases of service access, delivery and monitoring activities. In fact, the state very aggressively monitors a population which most states do not even consider as part of the long-term care case management population--the Medicaid nursing home population. But inclusion of this group in the target population for case management is a function of Oregon's innovative approach to the organization of long-term care that seeks to provide alternative community living situations--even for those in nursing homes.

Despite its adherence to a traditional full-spectrum approach to case management, Oregon has built into its program flexibility for the frequency of the monitoring function. Rather than prescribe the frequency of client contact, case managers are allowed to schedule monitoring contacts based on clinical judgement.

One finds in Oregon an institutionalized commitment to both client autonomy, as evidenced by the array of service modalities developed and available, as well as to a strong case management component. Case managers are perceived, and expected to act, as client advocates, assuring access and the delivery of quality services. There is no perception that these two elements--client autonomy and case management are In any way antagonistic, but rather that they complement each other and are necessary components of a system that is truly accessible and that respects and enhances client autonomy and quality of life.

VI. DISCUSSION

The approaches to rationing case management services in the programs investigated for this study vary. Four distinct models emerged: “Triaging” in the Ohio programs; “Stabilize & Discharge” in Washington State; a "Quasi Self-Directed” approach in Connecticut; and the “Traditional” approach in Oregon. Each of these is reviewed below and summarized in Table 2.

The “triage” model as employed in the three Ohio programs operates by classifying individuals on the basis of their need for immediate temporary services without case management oversight, need for minimal case management, or the need for intensive case management. The State of Washington, on the other hand, initially offers case management to all persons with multiple long- term care needs, but treats case management as a temporary service, one which is to be used for setting the care plan in place--one where the operating principle is "stabilize and discharge”.[25] Ongoing case management under this model, at least in principle, is not prescribed; most clients seem to be discharge from case management within 6-8 months of program enrollment. Connecticut is in the early stages o incorporating a “quasi self-directed” component to its long-term care program for the elderly. This approach acknowledges that some clients and/or their informal caregivers are capable of coordinating and monitoring care. The Connecticut model, however, deviates from the commonly held notion of consumer-directed or self-directed care where the client is responsible for hiring, training and directing his/her personal care attendant. In contrast, Connecticut still relies solely on agency providers, and designates a “lead agency”, usually a home health agency, to work with “self-directed” clients in coordinating their services, and if there is no agency willing to assume this role then regional state personnel are required to act in this capacity. The Connecticut model might be best described as a cross between a true consumer-directed model and an agency-directed model.

And last, is the traditional' model as exemplified by Oregon where all clients are case managed. However, the Oregon approach is not strictly traditional in that some flexibility is given to case managers in prospectively determining how frequently client contacts need to occur, based on professional judgement of client need. And thus, in a small way, case management services are rationed in Oregon as well. In a truly traditional approach all contacts, with the exception of client initiated communications, would occur on a predetermined schedule for all clients. It should be noted, however, that rationing does occur in programs that adhere to traditional case management models.

[25] In this context “discharge” refers to discharge from case management.

TABLE 2. Comparison of Five Programs With Alternative Approaches to Case Management				
Program	**Alternative Case Management Approaches**	**Population**	**Triage Groups**	**Eligibility Criteria**
Senior Options Franklin County, Ohio	Triage	Age 60+ (Excludes Medicaid HCBS Waiver)	Basic (≤ 6 weeks)	Mild, brief deficits in functioning & informal care
			Ongoing	Mild, long-term deficits in functioning & informal care
			Case Management	1+ ADL/7 or behavior/mental health/cognition problem and weak/absent informal supports
Elderly Services Program Hamilton County, Ohio	Triage	Age 60+ (Excludes Medicaid HCBS Waiver)	Basic (≤ 6 weeks)	1+ ADL/8 or 1+ IADL/8 or behavior/mental health/cognition problem
			Level II Care Management	1+ ADL/8 or 1+ IADL/8 or behavior/mental health/cognition problem
			Level I Care Management	1+ ADL/8 and no informal supports and one of the following: (a) recent change in medica, emotional or mental condition; (b) recent change in life status, e.g., death of spouse; (c) inability insure own health/safety
Aging & Adult Services Administration, State of Washington	Stabilize & Discharge	Age 60+ (Excludes Medicaid HCBS Waiver)	I&R	Requests assistance, needs advocacy or referral
			Case Management	Need for multiple services and weak informal supports
Home Care Program for Elders State of Connecticut	Quasi Self-Directed	60+ State Funded & Medicaid HCBS Waiver	Case Management	No stable/appropriate living situation; not obtaining appropriate health and medical care; needs assistance in securing social/economic resources; behavior problems; 4+ errors on MSQ; continued care by informal caregiver dependent on active intervention by case manager; unstable care plan due to changes in functional/cognitive status
			Self Directed Care	None of the above criteria apply
Division of Senior & Disabled Services State of Oregon	Traditional	Elderly & Age 18+ Disabled (including Medicaid HCBS Waiver)	No triage; all clients receive case management; frequency of contact can vary depending on client need for case management	At least some IADL disability

In such programs, rationing is not prospective, but rather it occurs by default. That is, in most such programs case loads are larger than optimal, and case managers resort to giving intensive attention to those with the most dire needs, resulting at times in inequitable oversight to other clients who are less demanding.

A major impetus for conducting this study was the option allowed to States in the long-term care component of the Health Security Act for the provision of ongoing case management. The proposed legislation also specified that only the severely disabled

would be eligible for the new community- based long-term care benefit. In this regard, it is notable that four out of the five of the currently operational non-traditional case management models described in this report serve populations that include the mildly and moderately disabled. Whereas the eligibility criteria stipulated in the proposed legislation was very stringent, requiring at least 3 ADL disabilities out of 5[26] or a comparable level of mental impairment, eligibility criteria for the programs reviewed for this study were, for the most part, much less restrictive. For example, in the Hamilton County Elderly Services Program one IADL would qualify an individual for services (but not necessarily intensive case management services). In the same vein, while Washington State's principle of "stabilize and discharge" is being applied to state-funded clients, ongoing case management services are still required for all Medicaid HCBS waiver recipient, i.e. those who at risk of institutionalization, and therefore presumably severely disabled. The issue, then, is if the client population in a new Federal/State program were limited to the severely disabled, would the rationing of case management services be appropriate? Do the severely disabled need ongoing case management?

Although very tentative, there is limited evidence that a prospective rationing approach to the provision of case management services may be appropriate for the severely disabled elderly population. The State of Connecticut, as described earlier in this report, is triaging all new and continuing clients in its Home Care Program for Elders into either on-going case management or "self-directed care" where clients are expected to assume the major responsibility for managing and monitoring their own services, with back-up from providers and state personnel, if necessary. In implementing this policy Connecticut is not making a distinction between Medicaid waiver clients, who by definition are severely disabled[27] and state-funded clients who may be less severely disabled. And although the Aging and Adult Services Administration in Washington State currently applies time-limited case management to state-funded clients only, they are considering amending their State Medicaid plan so that this policy may be applied to waiver clients as well.

Additional evidence suggesting that the severely disabled as a group do not necessarily require ongoing or intensive case management was forthcoming from case managers interviewed as part of this study, as well as Connecticut's early experience in administering their self-directed care program. In general, most case managers and administrators in all of the programs visited reported that level of disability, per se, is not the factor that determines need for ongoing or intensive case management. Rather, the intactness of the informal support system, seems to be the major determinant of the intensity of case management required, particularly for the elderly long-term care population. Clients with informal supports who are available, willing, and able to manage and monitor the in-home service package and to coordinate other health-related activities require less assistance from a case manager.

Other factors reported to influence the need for more intensive case management are captured in Connecticut's checklist used to justify the authorization for

[26] ADLs included bathing, dressing, toileting, transferring, and eating.

[27] See eligibility criteria for this group in Chapter IV.

case management: behavior problems such as abusive/assaultive behavior, wandering, behavior that threatens health/safety; continuation of care by informal caregivers dependent on active intervention of case manager; expected changes in client condition requiring frequent changes in care plan. Also specified as justifiable reasons for prescribing case management in this program are the following conditions which are viewed as temporary, and thus when resolved case management is expected to be discontinued, all other things being equal: unstable/inappropriate living situation; client not obtaining appropriate medical care; and client needs assistance in securing social/economic benefits, e.g., Medicaid, SSI, etc. Another factor, mentioned by virtually all case managers, that indicates the need for more intensive case management is the presence of mental health problems of either the identified client and/or the informal caregiver(s); these problems typically become obstacles in the client's willingness to access needed services, to positive interactions with providers, or to compliance with medical regimens. These situations usually demand more vigilant attention by a case manager. Case managers encounter similar challenges with clients and/or informal caregivers who are substance abusers.

Yet other situations that warrant more intensive case management involve client and their families who are racial or ethnic minorities who have not been acculturated to our society's values or who are unfamiliar with maneuvering within bureaucratic agencies. These difficulties are more often than not complicated by language barriers. Numerous examples of the obstacles that result from cultural incompatibilities were described in the chapters of this report, and represent various minorities living in different parts of the country. Once programs become cognizant of the cultural barriers to access for such populations and develop effective case management mechanisms to address them, there seems to be a parallel increase i the intensity of the case management services needed in order to effect authentic and continuing access.

What motivates programs to ration case management services? Is it cost containment or is it the best interest of clients? Certainly in an era of constricting resources and growth of the disabled population, costs concerns do command a central focus of most long-term care programs; programs seem to be continually searching for more economical ways to deliver services without compromising quality. In the four programs visited for this study that were truly rationing case management, each was grappling with cost issues, and clearly the selective offering of case management was a means for controlling expenditures. But there also seemed to be a genuine respect of client autonomy and decision making in these programs. At least two of the programs were consciously developed on the principle of “client knows best”. Moreover, most long-term care programs have been influenced, at least to some degree, and perhaps those included in this report, to a greater extent, by the disability movement that has lobbied very diligently for greater control over how care is delivered. The success of this movement is evidenced by the implementation of the consumer directed care model in numerous states, some of which include the elderly disabled population. Thus, whatever the primary motivation for rationing case management historically, it is becoming increasingly difficult to disentangle cost and client autonomy justifications imbedded in a policy to selectively provide case management.

All programs that ration case management must contend with the challenges that minimal or no case management presents for insuring that quality of care. Programs experimenting with prospective rationing are actively grappling with this issue. Each of the programs visited have implemented some type of monitoring, be that via telephone, in-person, and/or audits conducted by a quality assurance department. The frequency of monitoring contacts varies by program, and sometimes even within program by type of client. Providers are also relied upon, at least informally, to monitor clients, and are expected to report to back to the sponsoring program if they find anything amiss. None of the programs visited reported any major quality assurance problems, but concern was voiced on more than one occasion about the reluctance of many of the current cohort of elderly to monitor the care given by providers--either due to customary expectations about how to appropriately interact with health providers, i.e. “doctor” (and by extension, other providers) “knows best”, or out of fear of alienating and consequently losing a provider. Whatever the reasons behind this reluctance, it seems that regardless of the level of case management involvement, clients should be educated about how to be responsible consumers of long-term care--behavior which would increase their own autonomy, and which may also result in program cost savings.

In sum, there are currently only a handful of programs that prospectively ration case management services. One would expect that with both increasing cost constraints and the growing value placed on the autonomy of clients in all aspects of service provision, more programs will develop and implement mechanisms for selectively offering case management. The rationing of case management is a relatively new endeavor for most of the programs reviewed in this report. It will be both interesting and important to follow the progress of these programs described here, and others that may join them, to see how they evolve, and to learn from their experiences. Not all of the data is in, but the case studies included in this report provide some initial evidence for the appropriateness and successful application of rationing case management services, particularly to the elderly disabled.