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Supervision in Care Management: Managing Quality

Long-Term Care Management Turns 40: What We Know and What We Don't

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Background

In the introduction to our book on long-term care case management in 1990 we talked about its growing importance in the health and human services delivery system (Applebaum & Austin, 1990). Although some were calling it a fad at the time, today care/case management has become an integral component of many delivery systems including corrections, child welfare, substance abuse, mental health, acute health care, and long-term care services for the elderly and disabled. The litany of concerns identified as the rationale for long-term care management in the 1970s, including inadequate information for consumers, confusing eligibility criteria, a fragmented delivery system, a mismatch between individual needs and services provided, and poor quality of care, remain universal issues across an array of settings.

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While there are many faces of case management, this article focuses on care management with older people experiencing chronic disability. Although the actual term "case management" dates back to the 1960s, care management in the long-term services arena was first tested in a series of demonstrations in the 1970s (Reiff & Riessman, 1965; Kemper et al., 1987). Long-term care management expanded dramatically in the 1980s and 1990s with the passage of the home and community-based Medicaid waiver program, now implemented in every state in the nation (Eiken, et al., 2011). Care management, including a systematic assessment, arrangement and coordination of services, and monitoring the quality of the consumer experiences, has become a core element of the home and community-based delivery system. In addition, private care management has developed for individuals and families who have the necessary income to purchase their own services, but who still need assistance in navigating the complex system of health and long-term services.

With its own journal, academic course work, training, and certification, and professional associations, care management has come of age. In our 1990 book we argued that long-term care/case management was not well defined and that there was limited evidence to demonstrate its effectiveness. So as long-term care management turns 40 it seems timely to ask, what do we now know about care management and what do we need to know to make it a more effective component of the future delivery system?

What we know about care managers and long-term services

Most people do not give much thought to the tasks of daily living, such as taking a shower, getting dressed, or preparing breakfast. Yet, it is the need for continual help because of physical or cognitive limitations that results in older people receiving long-term services and supports (LTSS). The initial expansion of HCBS was driven by a desire to control Medicaid expenditures and to help individuals to remain as independent as possible in the hopes of delaying or avoiding nursing home use (Kemper, et al., 1987). These goals were later enhanced by the U.S. Supreme Court's Olmstead decision, which emphasized consumer choice about living environment as a civil rights issue, not just a cost control mechanism (1999). Dramatic changes in the long-term services delivery system over the last two decades has resulted in over half of the Medicaid population receiving long-term services doing so at home – a proportion that would have been unimaginable two decades earlier (Eiken, Sredl, Burwell, & Gold, 2011).

With this expansion, the care manager role in the provision of services and supports in the community has become a core element of the HCBS system. The care manager is involved as a consultant, counselor, and gatekeeper in a set of complex decisions made by and with the care recipient and their family. There has also been tremendous growth in home care services in the private sector, reflecting both the continued increase in the number of older people and individual, family, and societal expectations that older people with disability can live at home with the right supports. A growth in private geriatric care managers has accompanied these developments.

Today's care management involves an array of services and providers, often including a variety of settings. For example, care managers are now assisting in hospital and nursing home transitions, working to assure that the individual is able to return to the community, but also to assure that a person can successfully remain at home. Care managers are also playing an increasingly important role in facilitating physician-patient communications, and as more and more states shift to integrated models of care, the care management role could become even more important (Ortiz & Horne, 2013;Sinha et al., 2011). Additionally, the economic downturn generated a greater need for care managers to provide assistance with financial issues, such as those surrounding eligibility and enrollment for public benefits, credit and debt counseling, foreclosure and housing options, and legal services related to lost pensions (Firman, Nathan, & Alwin, 2009). A final growing area of practice for care managers is advanced care planning (Black, 2010), which has become more critical as the disability and frailty levels of those receiving services at home continues to increase.

As long-term care management turns 40, we have learned some important lessons about the provision of managed home and community-based services. At the dawn of the home care era critics were concerned that managing and providing services to frail older people in their homes was a safety risk. Research findings consistently showed either no impact on mortality or increased longevity for individuals receiving home and community-based services (Kemper et al, 1987; Applebaum, 2012). Similarly, concerns about safety risks and declines in physical functioning did not prove to be correct, but a number of studies did report improvements in quality-of-life indicators (Applebaum, 2012).

There were also concerns that the presence of a care manager and the expansion of home and community-based services would supplant the extensive support provided by family members. Results of the National Long-Term Care Channeling Demonstration and other studies found that families remained actively involved in the care of their loved ones, but in some instances appropriately shifted some of the major tasks provided (Kemper et al., 1988; Applebaum, 2012). Thus, families remain a critical component of the system and care managers have learned how to support individuals and families in the provision of long-term services and supports.

At 40, the ability to assess the needs of the consumer has become much more refined, as has recognition of the importance of incorporating the consumer voice into the care planning and service delivery process. What began as human service professionals prescribing the needed services has become a much more consumer-driven process

designed to maximize individual and family involvement. Providers have also had to adapt their approach, tailoring the services to the needs of the consumer rather than to simplify administrative tasks. Accompanying these advances have been technological improvements ranging from completing the assessment on a laptop to updating care plans and ordering services remotely and instantly.

At 40, the critical role of care managers in coordinating and communicating between systems and settings has been recognized. Whether it be the core care manager role in HCBS waivers, the major role in hospital and nursing home transition programs, or the emerging role in integrated care demonstrations, the care manager has become the glue of the long-term services system in the United States. There is now little discussion that care managers are a key component of any long-term services and supports program innovation.

What We Don't Know

Despite reaching middle age and achieving widespread expansion and popularity, there is much we don't know about the effectiveness of care management. Areas of uncertainty include both the work of care management and the expected outcomes of their efforts. For example, we still have unanswered questions about such basics as the optimum disciplinary training of care managers, caseload size, supervisory approaches, modes and frequency of assessment and monitoring, the most effective way to develop and implement a plan of services, how self-direction can work with and compliment the work of care managers, and how care managers will balance their roles in the new models of integrated care that accentuate the somewhat competing advocacy and gatekeeping roles of care management. There are also a series of unanswered questions about the impact of care management. Are consumers getting the right configuration of services? Has the care manager worked with the consumer to maximize independence? How has the care managed service package impacted participant quality of life, physical and mental functioning, hospital admission/readmission, mortality, and nursing home utilization? How can a care managed long-term services intervention achieve the best outcomes for consumers, their families, and the system? As the number of HCBS participants in both the public and private sectors continues to increase, the importance of assessing the effectiveness of care managed long-term services will multiply.

Why at age 40 is there still so much we don't know about care management? We have identified two challenges that impact the ability to assess care management effectiveness. First, extensive research in this area has tested care management combined with an expansion of an array of home and community-based services. Because the studies used care managers to develop and implement a plan of services the research tested the combination of care management and services. The studies did not attempt to isolate the care manager or service effect, such that we do not have good evidence about the effectiveness of the care management intervention.

The second factor, and perhaps the more challenging one, is that we do not have consensus on the goals and outcomes of care management. For example, what are the expected outcomes of the care management functions? Ensure that consumers feel included in the development of their services plan? Ensure that family members are satisfied with the plan of services? Ensure that family members will remain involved? Ensure that the participant has the needed services and supports to remain independent in the community? Ensure that participants achieve a better quality of life? Ensure that public or private resources are spent in an efficient and effective manner? Lower the use of nursing homes? Improve longevity and decrease health care costs? Ensure that the services delivered are the correct match for the consumer? Ensure that the services are provided in a high quality manner and that the services achieve the intended effect? Compounding the complexity of responding to these questions is that it is difficult to know which of these outcomes can be examined separately for the care management functions and the home and community-based services received.

To illustrate the challenges associated with assessing outcomes we choose an example from the quality area.

Quality of care is often measured in terms of participant outcomes, but there are no set standards for what is a "good outcome" (Enguidanos et al., 2003). Indeed, quality can be measured by health status, hospital readmission rates, length of residence in the community, or consumer and family satisfaction. In a qualitative study of professional care managers Kelsey and Laditka (2009) found that care managers view their role in maintaining quality of life as vital, and dependent on their ability to assist individuals in their efforts to live independently at home, arrange appropriate levels of care, and helping older people die peacefully and with dignity. The role of care managers in their contribution to consumer quality of life is also supported in a recent survey of care recipients (Ortiz & Horne, 2013). In light of the lack of sufficient quality measures, how are care managers to know whether or not they are doing "a good job?" Bowers and Jacobson (2002) identified six processes that characterized excellence. Some of the key processes included; developing and maintaining close relationships with consumers and their families, co-workers and supervisors, and service providers; respecting and facilitating participant autonomy; and the need for supervisor support. However, a lack of consensus on which of these factors are most critical means that it is difficult to develop clear and measurable outcomes of the care management intervention.

These challenges highlight why even though long-term care management is entering into its fifth decade many of the basic questions remain. Two very basic components of practice, caseload size and supervision, provide good examples of the difficulties. Every organization has to make decisions about the organizational structure of their care management program. Deciding how many consumers each care manager will work with and determining supervisory staffing patterns and approaches have substantial cost implications for both public and private agencies. A review of both of these areas shows tremendous variation in strategies across care managed programs. Caseload in the public sector can range from a low of 40 per care manager to over 200, while private care management practices typically have caseloads that average 15-20 clients. Supervisory ratios and function also vary widely. Efforts to systematically study even these basic management issues are limited by the lack of consensus about the intended outcomes of care management. If maximizing individual autonomy, enhancing communication with family members, and extensive monitoring of services are high priority outcomes then smaller caseload sizes may be necessary. If a program's most important goal is to serve a large number of moderately impaired older persons, then low administrative costs, higher caseloads and a lower expectation about the interactions between consumer and care manager would be expected. The lack of agreement about consumer and program outcomes means that systematic studies of questions like optimum caseload size or supervisory ratios and tasks have simply not been addressed. As individual programs have developed their own priorities and procedures they have developed their own practice patterns. But common outcomes and approaches to practice have not been established.

A Path Forward

Given this context, how can we generate better data about the effectiveness of care management?

What are the expected outcomes of care management?

It is clear that until there is agreement about the expected outcomes of care management our success in assessing the effectiveness of the intervention will be limited. But given the diversity of long-term care management programs is it possible to identify a core set of outcomes? While difficult, it is our contention that such a goal is achievable. The approach that we recommend has its roots in the early days of home care, when the motivation for expanding home and community-based services was consumer choice. In more recent years through such efforts as the expansion of self-directed care and the growth of private geriatric care management, the principles of consumer choice have become the bedrock of home care. Of course for consumers receiving services paid for

by the public sector there will always be tension between public resource expenditures and individual choice, but those difficult choices can be mitigated by a clear sense of program/individual principles. For example, if a driving principle of care managed long-term services and supports is to help the individual live in the setting of their choice whenever possible, measures to assess this outcome can be implemented. Use of nursing homes could be one outcome, but so could a measure that focuses on residential choice. Similarly, since involving the consumer in the development of the service plan is consistent with the principle of choice, this outcome could be a common one across programs. It is certainly expected that programs that focus on special populations or on a more extensive array of services, such as those integrating acute and long-term services, could have add-on outcomes, but it does seem possible to develop a core set of expected outcomes for care management.

Knowing what works

Once we have agreement about the outcomes of care management, then we can develop evidence-based practice standards. As we discussed earlier currently we do not have evaluative data on basic questions, such as optimum caseload sizes, disciplinary training, or supervisory ratios. We are even further from answering more nuanced questions, such as what is the right amount and configuration of services, what is the best approach for empowering consumers and their families, and how can care managers most effectively monitor the quality of in-home services provided?

To address these and other questions it will be necessary to use the same evidence-based practice strategies now being used in health and aging services. Practice areas such as caseload sizes, supervisory practices, assessment approaches, care plan development, or monitoring techniques can be incorporated into ongoing agency evaluation and improvement activities. Although we don't want to minimize the cost and complexity of these types of studies, they can be accomplished in the same way that evidence-based practices have advanced the state of knowledge in other areas. If care management is to remain a critical component of long-term services it will be critical to improve our understanding of what works and what does not. Seems like a good goal for a 50th birthday celebration.

References

Article References

Topics: Supervision

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