This is to certify that the

thesis entitled

The Use of Case Management in the Delivery Of Long-Term Care Services: What Health Planners Should Know

presented by

Robert G. Esdale

has been accepted towards fulfillment of the requirements for

Masters degree in Urban Planning

Major professor

Date November 11, 1987

THE USE OF CASE MANAGEMENT IN THE DELIVERY OF LONG-TERM CARE SERVICES: WHAT HEALTH PLANNERS SHOULD KNOW

By

Robert G. Esdale

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF URBAN PLANNING

Department of Geography
School of Urban Planning and Landscape Architecture

1987

#47345

ABSTRACT

THE USE OF CASE MANAGEMENT IN THE DELIVERY OF LONG-TERM CARE SERVICES: WHAT HEALTH PLANNERS SHOULD KNOW

By

Robert G. Esdale

Health planning includes a process for identifying and providing for the needs of the chronically ill or disabled. This is known as long-term care planning. Continuum of care is an objective of long-term care planning in which the range of needed services is provided in the least restrictive setting. This reverses the tendency to utilize nursing homes for care which could be provided in the community, thus permitting greater independence. Case management is a method of implementing this objective through assessing the client's need, developing a plan for services, monitoring the delivery of those services, and periodically reevaluating the client to determine change in health status. This thesis, in an examination of the long-term care system, describes the use of case management in national and state demonstration projects.

ACKNOWLEDGMENTS

The author wishes to acknowledge and express heartfelt appreciation to those whose understanding of the issues, and dedication to the advocacy for long-term care services for the elderly, have served to supplement the learning process and stimulate the thought and proposition contained in this thesis. Particularly noted is the counsel provided by Sister Mary Honora Kroger, RSM, Assistant Director of Programs on Aging, within the College of Human Medicine. Sister Kroger has not only been an invaluable reference source for material, but because she embodies the principles of scholarship for, advocacy of, and dedication to improving the quality of life for the elderly, she has also served as an inspiration for pursuing this important topic.

TABLE OF CONTENTS

LIST OF FIGURES

INTRODUCTION

Health care is a logical response to human beings' desire to maintain a consistent state of well being. Health care over time has evolved into a complex system of institutions, services and providers of those services. Health planning is a process by which the health care system responds to the needs and goals of the population it is intended to serve. When the phrase "long-term care" is used in reference to health services, the concept of nursing home care is usually perceived to be the care that is given. For at least thirty years, a form of care -- known as long-term care -- has emerged as a subset of the health care system. Nursing home care, as perhaps the most visible component of the long-term care delivery system, has derived the most attention largely because of its impact upon the lives of the patient, the patient's family and ultimately, upon all of society. Nursing homes may be a dominant force in the health care system, but are not the sole provider of service to the population in need of long-term care services.

For the health professional, social scientist, policy maker, health care planner and others, long-term care is identified with a range of medical care, nursing care, mental health care, and social services provided in response

to chronic illness and the aging process. The goal of providing these services is to maintain or improve the functional capacity of individuals and to maximize their independence. A range of noninstitutional forms of long-term care has been characterized as alternatives. Home health care, homemaker services and home delivered meals have independently evolved over the last several decades as services which provide the impaired or disabled in the community the ability to be cared for in their own homes. It might be said that these alternatives, also referred to as community-based care, have given the persons in need of long-term care an option to nursing home care. However, this should not be considered as a substitute for nursing home services, but rather an adjunct to that form of care in some cases. An appropriate characterization of the array of long-term care services is a spectrum, or a continuum of care.

This continuum of long-term care services includes the role of nursing home and alternative care systems within the health care delivery system. Nursing homes have been, and will probably continue to be, an important source of medical care for about 5% of elderly persons in need of care. The emergence of additional, community-based, care delivery mechanisms have facilitated this concept of a continuum. The concept is based upon a belief that persons with degenerating health problems progress from independent living, through supportive care in their own homes, ending in a

custodial care environment. The continuum concept in long-term care is deserving of attention by health planners because it is emerging in health care policy as a model for a collective of community-based services known as "alternative care". This alternative (to institutional-based) care has some assumptions which have made it attractive to policy makers. First among the assumptions is that it tends to support the elderly in less costly environments. Another is that supporting the elderly in their own homes using alternative care service is more humane, offering a higher quality of life for the "at risk" patient. It may be years before these hypotheses will be proven or disproved, but this has not abated the interest in continuum of care as a model for delivery of long-term care services. Methods by which this continuum will be implemented are being tested currently in the United States and elsewhere. The results of this research are important for health care planners because long-term care, as a subset of the health care system, or even as a system unto itself is under stress from the growing population of elderly in need of services, the rising costs of providing those services, and the increasingly complex environment of government, institutions, and advocates for change. Perhaps, in an environment as rapidly changing as the United States health care system, definitive answers to questions concerning long-term care issues of cost, access to care, and quality of the care given may elude planners for years.

What can be examined, and be of value to health care planners, is the emergence of a model for the implementation of this concept of a continuum of care. The premise of a continuum of care in a long-term care system is that there are supporting mechanisms which enable the planning and delivery of alternative forms of long-term care. One of these mechanisms, case management, is essentially based upon the planning concepts of: assessment, plan design, implementation, and evaluation. As an implementation mechanism, case management offers planners a source of data and experience from which to evaluate the continuum of care concept. The model of case management also serves to provide planners with data on health status, availability of needed services, and costs. Issues which arise from an analysis of case management can give planners a better understanding of the continuum of care concept. Given that case management, as a method of implementation, is in essence a planning model, the issues which emerge can provide insight and understanding to service coordination for the elderly.

The health care planner's role working within the health care delivery system has traditionally been to determine the quantity and distribution of necessary health care facilities and services to meet the need of the population, and to create a plan with strategies for obtaining its objectives. Implementation of a plan for long-term care services presents additional issues of quality of life, functional dependency, and the role of the informal care

giver, to the ever-present issues of cost, quality of care and accessibility to services. This thesis will look at these issues as they pertain to implementation of the health planning objective to create a continuum of long-term care services, and facilitate that continuum through the case management model. This model of health care service management has been researched at the local, state, and national level. Research findings have been varied, as have the issues focused on in the research. The case management model gives the health planner a definite process for coordination of service delivery and as such can be seriously considered as a resource in the planning process. The issues arising from implementation of case management programs across the United States may alert planning bodies to their future success or failure as a viable implementation strategy for the long-term care system.

The thesis begins with an overview of health planning, including the historical origins of facilities planning and the more recent efforts in community-based noninstitutional planning. Chapter two continues with an examination of the long-term care service delivery system. This includes a review of the growth of a system which has traditionally been dominated by hospitals and the nursing home industry. This chapter also deals with concepts of long-term care in a system in terms of its services and the environments in which those services can be provided.

Chapter three deals with the demographics which impact the long-term care system and methods of assessing the "at risk" population. This chapter examines the growth of the elderly population and the impact that growth will have in the demand for services in the future. The chapter also provides a description of some of the methods used to establish a level of care needed for long-term care services.

The costs of long-term care and the effect of population growth upon those costs are discussed in chapter four. Funding of long-term care services through Medicare, Medicaid, and other programs will be described. These two chapters provide the background necessary to understand the demand and supply of long-term care services. With this understanding a management model for implementation of the continuum of care concept can be described.

Chapter five deals with the development of that model, case management, for coordination of the various forms of long-term care for the elderly. The case management model is viewed as an implementation mechanism for alternative services. Chapter six offers an analysis of three demonstration projects, which used centralized assessment and tested the use of case management as a vehicle for providing community-based services.

A pilot project currently underway in Michigan to use case management in the delivery of alternative services is the focus of chapter seven. This case management model, known as Care Management, includes the evaluation of elderly

persons and coordination of services to meet their needs in the least restrictive setting. From the analysis of the national and state level case management projects, the issues surrounding the use of case management as an implementation strategy for providing the continuum of long-term care services will emerge. Chapter eight concludes the thesis with a summary and recommendations regarding the case management model.

Chapter One: Health Planning

Planning is essential to the functioning of any complex organization or system where many related components must function in a coordinated fashion to achieve efficiency and optimal performance. Planning can not only be characterized by the field or endeavor it focuses on (health, housing, transportation), but also by the level at which it takes place (federal, state, local) and by the methods employed (consensus, technocratic). Planning can cover various periods of time, and therefore be characterized as long-range or short-range. Planning also includes sets of different dichotomies: strategic versus tactical; or system versus project. The process of planning can be considered as a multidimensional endeavor within a multifaceted system.[1] Thus health planning, as a component of the health care system, exists as a range of methods, options, and variables, including mechanisms for implementation and evaluation, in a constantly changing environment. At its best, health planning results in an effective and coordinated use of resources at all levels of society. At its worst, health planning creates barriers to delivery of desired, if not needed, services. If medical care is an appropriate response to illness, then health planning is an

---

[1] James Kimmey, M.D., Health Planning in the United States, (Madison, Wisconsin: Institute for Health Planning, 1982), p. 90.

appropriate response to the quality, cost, and access to that care.

New technology provides the mechanisms to sustain and improve life. This in turn creates higher expectations within society. In theory, health planning converts these expectations into goals for the health care system to meet, and defines strategies or mechanisms to meet those goals. The health planning process focuses on the services and institutions within the health care system which exist or must be created to address the need of the population to be served. Implementation of health policy resulting from the planning process may be at a system level (creation of services and facilities), or at an individual level (client-based assessment and service delivery). Implementation is thus evaluated on both a system and individual level.

From a historical perspective, health planning was originally performed for the purpose of preparing a year's operating budget, or designing and implementing a specific capital project. This planning occurred primarily in institutions or large service-oriented agencies, and generally was not coordinated with other health-related activities in the community or the region. Limited, restricted planning such as this changed as a result of new reimbursement and regulatory requirements, diminishing resources, and a more competitive environment. Institutions have slowly begun to take a broader approach in assessing the community impact of their plans.

The community interest in planning for the development of health services and facilities was originally linked to community fund-raising drives undertaken by various unified campaigns serving the needs of multiple health and welfare agencies.[2] The necessity to allocate funds among a variety of agencies led to the formation of community councils, which, among other activities, developed health plans and implementation mechanisms for their communities. Corporate philanthropy in health care served as another impetus for community-based health planning. Hospitals and industry cooperated in the development of Hospital Review and Planning Councils. These councils were responsible for developing community facilities plans, and for reviewing individual hospital proposals on the basis of those plans. Without the endorsement of the local planning body, it was difficult for hospitals to raise funds for their project among corporate givers.

Like community level health planning, federal and state health planning originally began with a facilities focus. The original impetus came from the Hospital Survey and Construction Act of 1946 more commonly known as the Hill-Burton Act. This federal legislation provided money for construction of facilities, principally new hospitals in areas where there was not an adequate supply of hospital beds to meet the needs of the population. The Act also required states receiving funds to do health planning in the

---

[2] Ibid., p. 103.

following context: 1) a physical assessment of institutional capacity; 2) determination of areas of need; 3) recommended actions, in the form of plans, to meet defined needs; and 4) priority setting for construction or replacement of facilities which provide services. Until 1965 this was the only state health planning effort linked to federal funding.

The passage of amendments to the Social Security Act in 1966 began a new phase in federal and state involvement in health planning. These amendments created the Medicare (Title XVIII) and Medicaid (Title XIX) programs, providing funds for health care of the elderly and persons of low income, respectively. With the direct payment of services to individuals the federal government was in the position to influence the methods of providing care to specific population groups. This was, and is accomplished through program eligibility requirements for recipients (clients) and service delivery requirements for the providers of health care services.

Planning at the state and local levels was further enabled through enactment of section 314(d) of the Public Health Services Act of 1966. This allowed for the creation of area-wide comprehensive health planning agencies which, through planning boards, addressed services to individuals in their communities. Unfortunately, their enforcement power was limited to persuasion, which often did not impact upon the local health care facilities.

Ultimately, the passage of the National Health Planning and Development Act in 1974 by the United States Congress provided a mechanism to integrate facilities and nonfacilities planning efforts at the state level. Under the legislation, federal funds were provided to designate State Health Planning and Development Agencies (SHPDA) to support the efforts of consumer-oriented advisory bodies known as Statewide Health Coordinating Councils (SHCC) in developing comprehensive state health plans. The SHPDA would also develop a state medical facilities plan, which calculated the needed number of facilities and services, and was consistent with the goals of the comprehensive plan. The legislation also enabled states to designate local areas for planning purposes and set up local Health Systems Agencies. These agencies would develop health plans based upon the local needs of their service areas, and review proposals for additional facilities on the basis of those plans. The state, in turn, would approve or deny a proposal using the input from the local Health Systems Agency. The intent was to insure that new facilities and services were consistent with the populations need for those services. This was known as the Certificate of Need Process, and until the repeal of this legislation in 1986, this served as the mechanism by which need and the provision of health care services were addressed in a planning process.

Long-term care services were generally addressed in the plans created by Health Systems Agencies. However, it was

not until the mid 1980s that health plans went beyond assessing the need for nursing home beds and began to look at community alternatives. Home health care, home delivered meals, chore services, respite care for persons providing uncompensated long-term care, and hospice services were some of the community based alternative services which received attention in local health plans. This resulted primarily from public demand for support of these services.

In theory, health planning occurs to bring about social change. The principal characteristics of social planning are: the defining of desired improvements, the implementation of programs and projects to achieve a desired improvement, and the measurement or evaluation of the achievement. One component of this process is the concept of building for the future: that is, defining what should be done at this time so that the health care system will operate to meet the public's expectations and satisfaction in the future. A more system-oriented component is that of problem solving: what is needed now to meet the demands of the public at this time. Health planning as a product of societal growth and change, has attempted, through implementation, to address the issues of access, quality, and cost of medical care. It is necessary to maintain balance between what is desired for the future and what is needed now. It is also important to have a broad base of participation in the health planning process, because no one individual is likely to conceive of all the options available.

Health planning is developmental in that it requires a simultaneous focusing on short-range planning for problem solving and long-range goal attainment. The planning techniques employed must be complementary in a systems approach to improvement through change. Finding solutions to current problems should not act as constraints to the attainment of a long-range goal. Through implementation strategies the planning process interacts with service and institutions in attaining the goals set forth in the plan. Plan implementation should not create conflict between solving an immediate problem and creating an environment compatible with the attainment of a long-range goal. Monitoring of the implementation process should include an evaluation of any conflict between short-term problem solving and long-range goal attainment.

Two approaches to implementation are: system based, the creation of facilities and services; and client-based, the personal interaction with individuals to address need. Criteria for choosing methods of implementation should include the avoidance of immediate or future reactionary measures which result from desperation, frustration, or the failure to reach a satisfactory social solution. Because of this, it is important to reverse a historical trend of using only a systems approach to health plan implementation. It is equally appropriate to address the need of caring for elderly through implementation of policy and plans at the level of those receiving the service. The creation of

Chapter Two: Long-term Care

According to the U.S. Department of Health and Human Services, long-term care consists of "those services designed to provide diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance services for individuals who have chronic physical and/or mental impairments in a variety of institutional and non-institutional health settings, including the home, with the goal of promoting the optimum level of physical, social and psychological functioning."[3] This definition implies a complex set of related services affecting not only the patient who is using them, but their families, their communities and the health care delivery system as well. While the definition is not exclusive to the aging population, it is generally considered in a context of the elderly because that group represents the largest proportion of the population needing long-term care services.

Long-term care has distinctive features that set it apart from acute, episodic care. Acute care is usually associated with disease or injury with sudden onset and limited duration. Long-term care responds to chronic, degenerative, and disabling conditions which are often exacerbated by the age of the patient and the aging process.

---

[3] Division of Long Term Care, U.S. Department of Health and Human Services, quoted in American Health Planning Association Publication, A Guide for Planning Long Term Care Health Services for the Elderly, (Washington, D.C.: AHPA, 1983), p. 7.

institutions such as hospitals and nursing homes has resulted in pressure on financing mechanisms to support them, leading to confinement of those in need of care in those institutions, irrespective of the level of care which is needed. This is incompatible with a larger societal goal of personal independence. Thus, there is emerging an impetus to reverse the trend of institutionalization, and to improve individuals' health through the use of community-based alternatives in the health care system.

Long-term care planning, as a subset of health planning, addresses those unique needs and expectations of the elderly who may have limited physical capacity or have chronic illness. Planning for long-term care services exists on several levels: national, state and within the local community. Implementation strategies include systems and client-based approaches, with the latter becoming more of a popular trend. The current long-term care system is a result of the input from many sources, institutions, providers, policy makers, and advocates for the elderly. Definitions, regulation, and resources have flowed into the long-term care system for years without the benefit of a comprehensive national policy for long-term care. This has resulted in a fragmented system of institutions and services funded by a variety of programs. An impression is that the nursing home industry dominates this system. The next chapter looks at the evolution of long-term care in the United States and the various influences on its development.

Chapter Two: Long-term Care

According to the U.S. Department of Health and Human Services, long-term care consists of "those services designed to provide diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance services for individuals who have chronic physical and/or mental impairments in a variety of institutional and non-institutional health settings, including the home, with the goal of promoting the optimum level of physical, social and psychological functioning."[3] This definition implies a complex set of related services affecting not only the patient who is using them, but their families, their communities and the health care delivery system as well. While the definition is not exclusive to the aging population, it is generally considered in a context of the elderly because that group represents the largest proportion of the population needing long-term care services.

Long-term care has distinctive features that set it apart from acute, episodic care. Acute care is usually associated with disease or injury with sudden onset and limited duration. Long-term care responds to chronic, degenerative, and disabling conditions which are often exacerbated by the age of the patient and the aging process.

---

[3] Division of Long Term Care, U.S. Department of Health and Human Services, quoted in American Health Planning Association Publication, A Guide for Planning Long Term Care Health Services for the Elderly, (Washington, D.C.: AHPA, 1983), p. 7.

Diseases commonly associated with the elderly -- heart and vascular disease, arthritis, cancer, and certain mental disorders -- ultimately result in the use of long-term care services. Often, illness in the elderly is a multiplicity of diseases and impairments. The cumulative effects of combined morbidities associated with age imply that "as many as 30% of the population 65 and older require some assistance."[4] Many of these people are in need of support services in addition to health care services. Some in fact may only require basic assistance with the functions or activities of daily living (ADL) which they can no longer provide for themselves.

The most apparent and visible component of long-term care is the nursing home. This is partly due to the role of the informal care givers, family and friends who provide a great deal of the services in non-institutional settings. These services are generally not reimbursed, and therefore not part of any data base which measures quantity or cost. The costs of nursing home services constitute a larger portion of health care expenditures, and thus nursing home care receives greater attention from health care planners and policy makers.

Nursing homes and other forms of institutional care have been said to dominate the formal long-term care industry, in every sense of influence and impact in the long-

---

[4] Ronald J. Vogel and Hans C. Palmer, eds., Long-term Care: Perspectives from Research and Demonstrations, (Rockville, Maryland: Aspen Systems Corp., 1985), p. 3.

term care system.[5] Evidence of this domination is measured through the payments made by Medicaid, Medicare, other third party payers, and individuals.

In Michigan there were 46,562 patients in nursing homes in 1980, according to the census for that year. Most of these patients had all or part of their care financed by the Medical Assistance Program (Medicaid). The Michigan Medicaid program costs were $500 million that year for the care of patients in skilled and basic care nursing homes.[6]

The dominance of nursing homes in providing long-term care has its origins in a modification of the Old Age Assistance Program ratified in 1956, to allow for financing of care in nursing homes. Under this program federal matching of state funds resulted in more people having their care in nursing homes financed through sources other than their personal assets. This trend continued, and by the mid 1960s, with the enactment of the Medicaid Program, the portion of federal monies grew faster than the states' share. The result of this financing formula has been a "five-fold increase in the number of nursing home beds since 1950."[7] Forty percent of those beds were needed just to keep up with the growth of the elderly population, including

---

[5] U.S., Department of Health and Human Services, Proceedings, Issues in Planning for Long-term Care, September 15-16, 1983, Washington, D.C., p. 19.

[6] Michigan Department of Social Services, Data Reporting Section, Medical Assistance: Fiscal Year 1980, Pubn. 122, (1980), p. 30.

[7] Proceedings, Issues in Planning, p. 19.

the increased numbers of elderly living beyond the ages of seventy-five and eighty-five years. However, sixty percent of that increase in beds, driven by guaranteed reimbursement, resulted in a "doubling of the utilization rate of nursing home care between 1950 and 1958. By then the nursing home census represented five percent of the elderly population nationwide."[8] In the 1970s this growth stabilized, helped by state incentives and reimbursement restrictions. Since the mid-1970s growth has kept pace with the increased growth in the elderly population.

At the time of the start of this growth period, in 1950, nursing homes were perceived as rest homes, staffed by personnel with limited training. The patients were often not very sick nor overly dependent. Elderly patients with chronic illness were cared for in hospitals, even if that care lasted for many months. As states began to fund more of the care in nursing homes, through their Medicaid programs, they took a greater interest in the types of patients (level of disability) living there and the standard of care they were receiving. In a national survey of nursing homes in 1977 it was documented that fully half the patients were dependent in almost all activities of daily living, indicating that the majority those living in nursing homes comprise a very sick population.[9]

---

[8] Ibid., p. 20.

[9] Ibid.

The states' decision to use federal monies appropriated for Medicaid to pay for nursing home services has resulted in increased attention to standards in nursing home care. The Medicaid program, as payer of those services, held leverage in the enforcement of those standards. However, nursing homes should not be thought of as mini-hospitals. The amount of physician care, and the nurse-to-patient ratio does not come close to that which exists within a hospital. Patients residing in nursing homes will continue to receive acute care in a hospital setting when their physical condition requires it.

Another factor concerning nursing homes worth noting is that the majority of nursing homes are private, for profit, enterprises. This has been attributed to the increased funding for nursing home care which began over three decades ago. Starting in 1950 when the number of government (local) owned nursing homes roughly equaled the number of proprietary homes, the growth has been almost entirely in the privately-owned facilities, with multi-facility corporations becoming the dominant factor in growth over the past ten years. In one year the top twelve nursing home companies added a total of 50,000 beds, a growth of over thirty-three percent, to their bed inventory. Proprietary nursing homes now represent about seventy percent of all the nursing home beds nationwide.[10] With an investment of this magnitude, proprietary nursing homes wield considerable

---

[10] Ibid.

influence in the planning and distribution of long-term care resources.

This change in nursing homes and the influence of the nursing home chains have left many with the feeling that the growth of institutional care has become excessive, in terms of resources consumed, to the detriment of alternative forms of care. Nursing home expenditures are the fastest growing component of the health care system, with a nationwide annual growth averaging seventeen per cent by some estimates. The response to this growth has been an attempt to limit the supply of nursing home beds through the licensure process, and to expand the use of non-institutional care services as a less costly alternatives.

In the health planning process the efforts to shift from institutional care to community based alternatives is influenced not only by the costs for alternative services, but also by the role played by the care giver. Nearly three-fourths of the care given to the elderly is from family and friends. If a parent lives to the age of eighty, the caregiving son or daughter is likely to be between the age of fifty or sixty years. This means that the care givers are approaching the age of retirement and the subsequent loss of income. Furthermore, the trend in this country is toward a growing number of women holding jobs outside of the home. Since caring for an elderly parent often falls to the daughter, this could mean that these women must give up employment, pay for household assistance,

or not provide the elderly parent with care. Even with the strong moral and emotional incentives to do so, households with women working for economic reasons are often unable to make the sacrifice necessary to provide for care in their homes. Taking care of elderly patients places a significant burden on families when there are few community resources available to help. Mechanisms to implement community-based services must, therefore, recognize the needed support for the informal care giver in order to be a realistic alternative to institutionalization.

Community alternatives to the requirement for constant care from the family member or friend will greatly enhance the transition from institutional to in-home care. Services such as adult day care, sitter and homemaker services could go a long way in reducing the number of patients who are placed in nursing homes because of the lack of available care in the home.

The description of a long-term care system dominated by institutions, such as the nursing home industry and federal and state reimbursement programs, is not what the literature characterizes as the "desired system" to meet the needs of chronically ill or disabled persons. It is useful to broaden the definition of long-term care, to further understand a more rational approach to the system.

Hans Palmer characterizes long-term care as a time-related process, with implications for providers and users of the services as well as planners and policy makers. He

believes the longitudinal aspect of long-term care for the patients and their supporting family and friends is a dichotomy, affecting not only the capacity to recover, but also "a sense of loss of control over the manner in which time is spent by the care-giver, who is usually a family member."[11] More research in this area would further distinguish the allocation of time to the care of adults by family members. Palmer further describes time as an input to, and an outcome of, the process of providing long-term care services. Time is part of the curing process, i.e. the recovery from a stroke, and it is also a desired goal when long-term care extends one's life, particularly if the quality of that life is maintained. This also is an area appropriate for further research. Some recipients of long-term care services will improve and require less services in the near future, while others will receive those same services and continue to deteriorate because of the aging process.

Given the broad scope of long-term care, in terms of its definition, and the relationship that it shares with time, it is useful from a planning perspective to view it systematically. Thus, long-term care deserves recognition in policy and planning at the national, state, and community levels as a system of care, with a wide range of services and settings, serving many categories of persons in need of those services.

---

[11] Vogel and Palmer, p. 8.

Unfortunately, this generally is not the case. Traditionally, long-term care services were not recognized as anything more than health services applied to a specific population group. And as states and local communities have been challenged to view the long-term care system as an entity unto itself and develop improved approaches to the organization and delivery of long-term care services, federal support for this effort has diminished. Furthermore, as a subset of the health care system, long-term care has been viewed historically as a collective of separate responses to specific problems. In an analysis of forty-two Health Systems Agency Plans, Brody and Woodfin found only a few health planners looked at services across a range of settings.[12] In cases where a service (e.g. nursing) was considered in a variety of settings, there were no distinctions as to the different roles that service played, dependent upon the setting. At worst, the concept of long-term care has been considered as only services provided in a nursing home setting. One of the most pervasive misconceptions, which has been evidenced in previous health planning action, is that long-term care represents only health services, and not the variety of services suggested by its definition.

---

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration, State Initiatives in Long-Term Care, (Washington, D.C.: Alpha Center Monograph, August 1984), p. 59.

Conceptualization of long-term care as a matrix of services and settings has been developed in several policy arenas. Of note are the "Veterans Administration Placement Alternatives by Level of Care Needed" and "Array of Possible Housing Settings for the Elderly and Services Inherent in Each Setting" by the Urban Institute. The Veterans Administrations model relates placement alternatives to levels of disability. This model shows that a variety of choices of providers of services exist, and that assessment of the individual will establish a level of need for those services (Figure One).[13]

The Urban Institute model is a matrix of services in various settings, from independent living to the hospital and nursing home. This model shows that there exists a range of settings in which needed services can be provided (Figure Two).[14] The common denominator in both of these models is the environment of the person receiving services. Both models can be compared on the basis of the relationship between functional ability of the individual and services required to enhance functional ability.

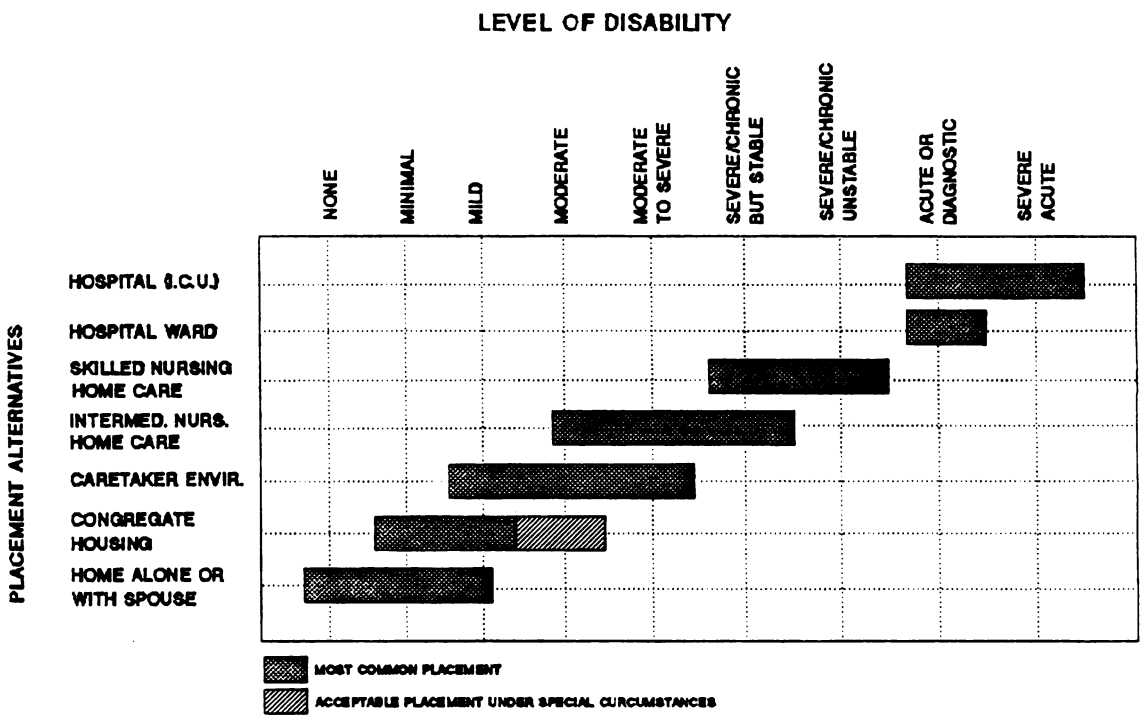
Because of the relationships between the three variables, it is possible to combine both models and look at long-term care as a three axis matrix. Services, settings and functional ability become the basis of a long-term care system which exists as a continuum. This concept of a

---

[13] As illustrated by Vogel and Palmer, p. 11.

[14] As illustrated by Vogel and Palmer, p. 10.

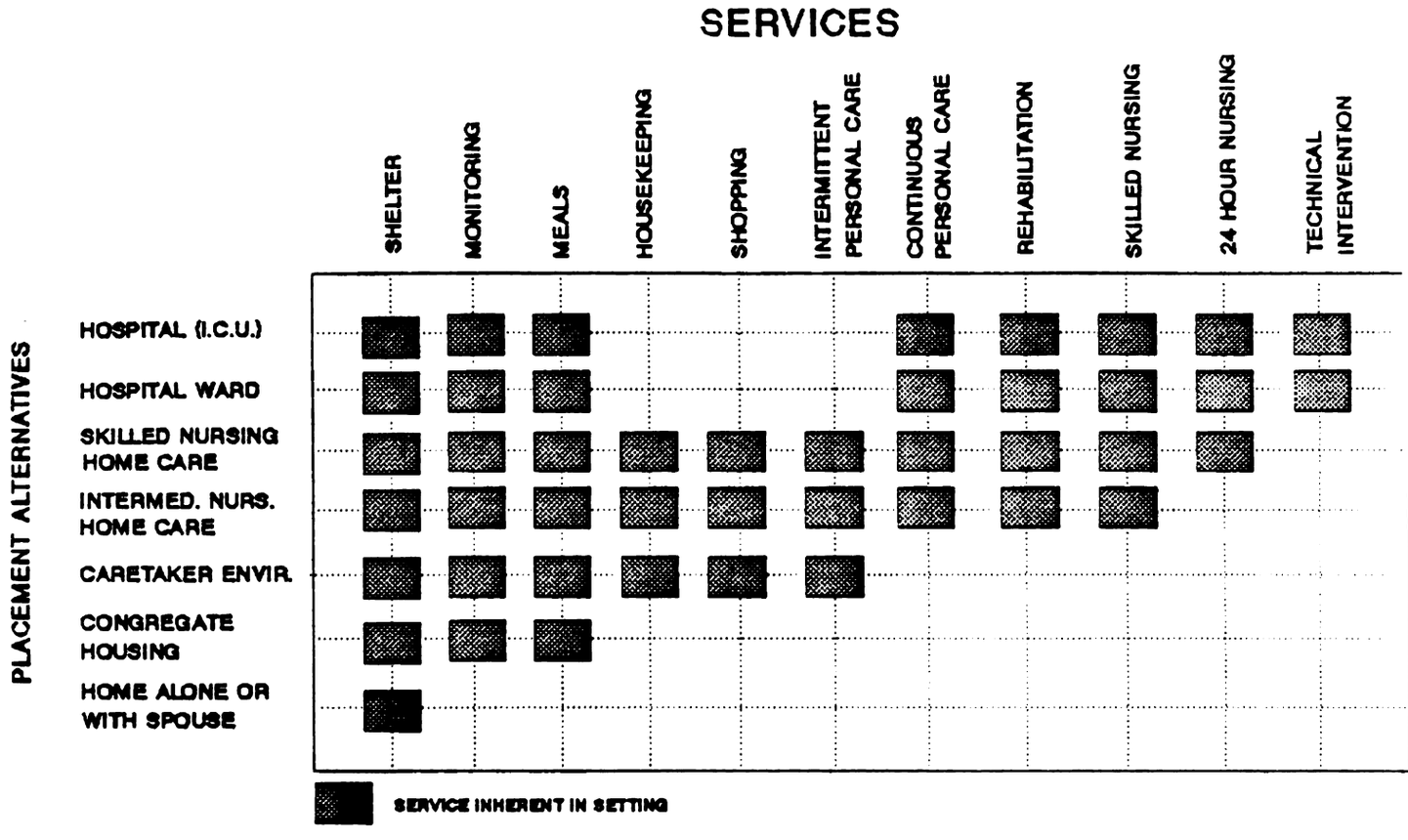
Figure One



SOURCE: "The Aging Veteran - Present and Future Medical Needs" (Adaptation)

Placement Alternatives based upon Disability

Figure Two



SOURCE: DiFrederico, et.al., URBAN INSTITUTE, 1979 (Adaptation of Orginial)

Appropriate Settings for Long-term Care Services

long-term care system begins with minimal service in an independent living arrangement, and progresses towards a vast array of caretaker services for the institutionalized disabled. A consensus in health planning has emerged on a continuum of care based on the following objectives:

> Rehabilitation - Restoring the individual to some previous level of functioning that can be sustained.
>
> Maintenance - Insuring the maximum possible independence of an individual at all times even if there are limitations in activity or deterioration of functions.
>
> Prevention - The slowing of deterioration by anticipating and acting on concerns that are avoidable, before they occur.
>
> Protection - Providing humane care for persons who are functionally and permanently dependent, even to assure death with dignity for those in the dying process.
>
> Prolonged Longevity - Providing those services that are necessary to maintain life.[15]

This method of classifying services, settings and disability into a system which has the stated objectives for a continuum of care results in a model of the long-term care system which includes a full range of services. These services are designed to be provided over time as the aging process and other physical or mental conditions progress to limit one's ability to perform needed life functions. The services can be provided in many settings, including a person's home, congregate living arrangements, other community settings, or an institution. Furthermore, the placement of persons is dependent upon a referral and assessment process which evaluates the individual and determines the

---

[15] A Guide for Planning Long Term Care, p. 9.

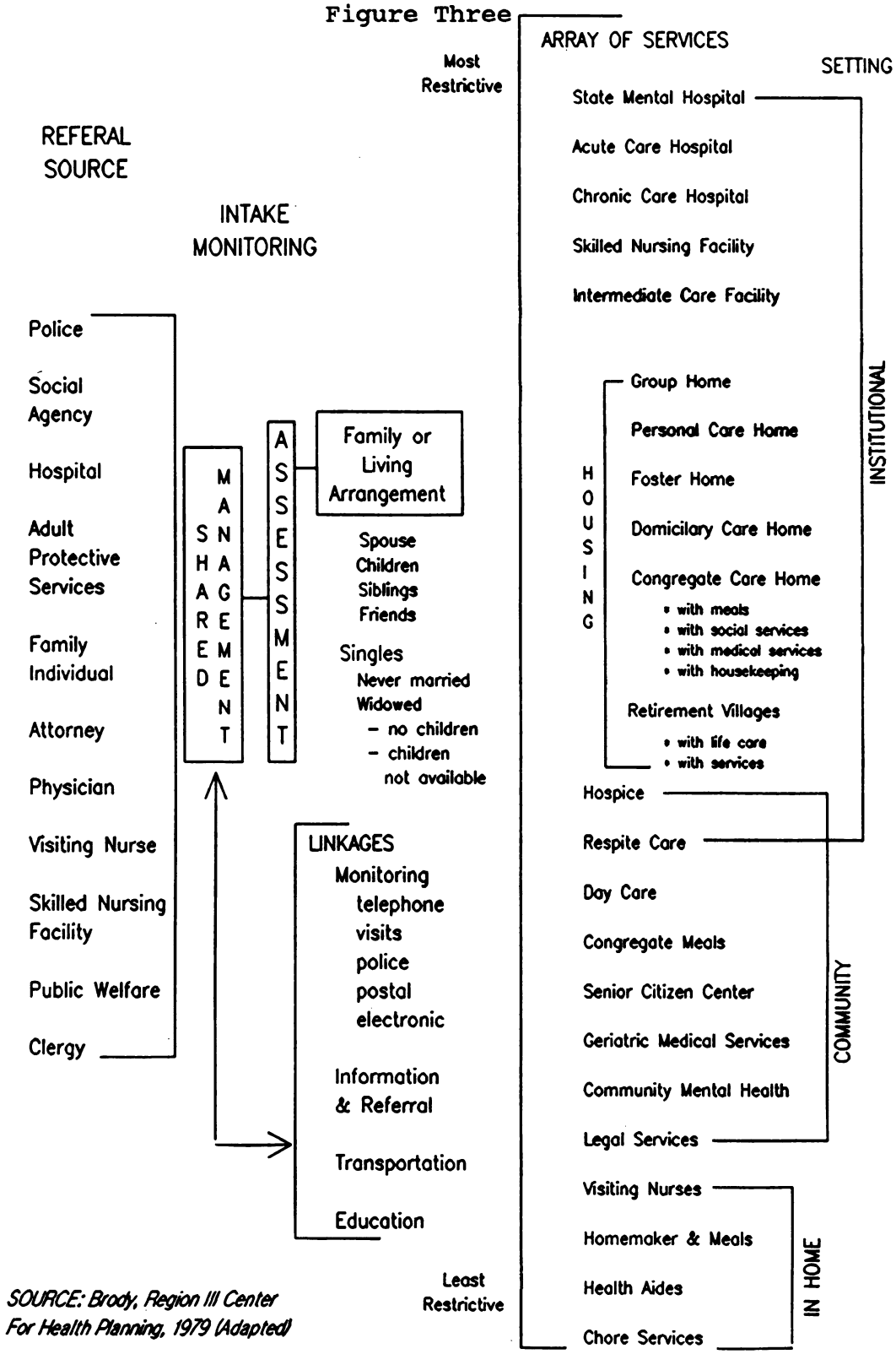
level of care which is appropriate. This therefore indicates that implementation of this model requires third-party management, of at least the assessment and placement process. Coordination within the system is a function of client management. Ideally this management serves the objectives of a continuum of care, and not specific institutions providing that care. A model, designed for Region III Center for Health Planning in Philadelphia, considers these relationships (Figure Three).[16] This model further illustrates a continuum of settings, from most restrictive to least restrictive, with an overview of services available in those settings. This model also includes referral and assessment component as a third-party intermediary, which serves as gatekeeper to the long-term care system.

While these models are useful in considering a design for a long-term care system, one is reminded that to a large extent that that system does not exist, there remain many gaps in the system. It is also important to recognize that the development of services and institutions have occurred over time, from diverse forces in society, government, and private industry. Funding mechanisms have not been coordinated to achieve maximum efficiency in the use of resources. Interested parties have, at times, worked at cross

---

[16] Stanley J. Brody, Planning for the Long Term Support/Care System: The Array of Services to be Considered, a monograph prepared for Region III Center for Health Planning, (Philadelphia, Pennsylvania, June 1979).

Figure Three



SOURCE: Brody, Region III Center For Health Planning, 1979 (Adapted)

Long-term Care as a Continuum

purposes, resulting in what may more appropriately be described as a long-term care "non-system". The goal of a continuum of community-based services is justified by current gerontological research, which has resulted in several conclusions worth noting:

> There is some evidence that community-based services do act as a substitute for nursing home care, at least for a small portion of the individuals served.
>
> In some programs the costs of care per individual served are higher than nursing home care, and in others costs are lower, depending upon the extent of care needed.
>
> Community-based programs have often increased system-wide long-term care costs because they serve many more persons than simply those who would otherwise be in nursing homes. They offer services to more people in the community who need them and therefore can increase demand.
>
> There is evidence that community-based services improve patients' outcome. Many programs show that patients live longer and have higher levels of mental functioning, self-maintenance, satisfaction with services, and higher life satisfaction.[17]

Successful planning of community-based programs are dependent upon policy and funding mechanisms. Prior to policy formulation, however, an appropriate step in the planning process would be to determine what services are needed, and what levels of care are needed for individuals. This requires methods of matching the needs of the elderly with the community-based services, and monitoring the results on the basis of cost, accessibility and quality of care.

---

[17] National Association of Area Agencies on Aging, Statement on Community Based Long-term Care, (Washington, D.C.: NAAAA 1983), p. 4.

Failure by the federal or state governments to provide an appropriate resources in response to the need for a continuum of long-term care has created a fragmented maze of institutions and services in this society. Elderly consumers and their families are often confronted with multiple programs and agencies at the federal, state and local level without any apparent centralized responsibility for either providing access to various programs or meeting needs of the clients who fall outside of a particular program's scope. A report of the Special Committee on Aging to the United States Senate cited the lack of coordination of long-term care services as the single most perceived problem.[18]

These problems become intensified as the number of elderly in the population grows. The next chapter looks at the demographics of the elderly population and methods of assessing their needs.

---

[18] U.S., Congress, Senate, Special Committee on Aging, Long-term Care in Western Europe and Canada: Implications for the United States, S. Rept. 98-211, 98th Cong., 2d sess., 1984, p. 14.

Chapter Three: The Elderly Population and Assessment of Need

In planning a continuum of long-term care services, two variables emerge as significant to the process: the portion of the elderly population in need of long-term care services and the method of evaluating or establishing an individual's need for those services. This chapter deals with demographics of the aged population group and a discussion of the "at risk" group, and how their need for services can be determined. The following chapter will describe the programs which exist to supply funding for the continuum of needed services.

The definition of "elderly" as used here will reflect those over the age of sixty-five years, the age established in 1935 by the Social Security Act for providing benefits. The Older American Comprehensive Services Amendment of 1973 to the Social Security Act reduced the optional age for retirement to sixty years. This was done to conform with the age established by the Older Americans Act for eligibility for the nutrition program. Additional terms, the "frail elderly" and "very old," are often used to describe persons over the age of seventy-five and eighty-five years, respectively. These terms are not embodied in federal legislation, but are used widely in the long-term care system. The fact is that many definitions describing population characteristics have emerged from use by those working in the field to become defined by statute.

The number of persons who will represent a population potentially in need, in a given geography, is dependent upon three factors: the birth rate, the death rate, and migration. Migration for purposes of population growth means immigration from other geographies. The impact of immigration on the growing number of elderly in the United States is attributed to the influx of young immigrants between 1900 and 1940. This migration into the nation also influenced the increased birth rates throughout the century.

At the state and local level, migration may contribute significantly to increases or decreases in population age groups. It is widely accepted that migration of the elderly from cold weather regions to warm weather regions occurs both seasonally as well as on a permanent basis in this country. Migration from Michigan to "sun belt" states such as Florida and Arizona has increased steadily during the past three decades. During this same time migration of the elderly within Michigan was occurring. Since 1960 the metropolitan counties where central cities are located have experienced increased out-migration while rural counties have experienced an increase in their elderly population, especially those in the northern part of the Lower Peninsula.[19] This is significant in that community-based long-term care services are not as available in rural areas

---

[19] Michigan Office of Services to the Aging, The Aging in Michigan: A Population Profile of the Elderly, by Ching-li Wand and David Youngs, (Lansing, MI: OSA, 1984), p. 5.

as they are in metropolitan areas. There are implications for access to care that health planners must recognize.

Based upon the mortality rate of 1900 for the United States, a person born in that year could expect to live an average of forty-nine years. Data compiled by the Michigan Office on Services to the Aging shows that at the beginning of the century, eight percent of Michigan's 2.4 million residents were older than sixty years, and only five percent of the population was older than sixty-five years. By 1940 the national average life expectancy at birth had risen to sixty-three and one-half years. There were about nine million people over the age of sixty-five living in the United States. Of this group, less than three million were seventy-five years or older. In Michigan during this period, 330,854, or six and two-tenths percent of the state's 5.3 million population were over the age of sixty-five, and 101,000 (one and nine-tenths percent) had survived beyond the age of seventy-five years. By 1954, life expectancy at birth for Michigan residents had increased to seventy years, and by 1982 it had risen to almost seventy-four years.[20] The increased longevity can be attributed to a change in epidemiology, where deaths from infectious diseases were replaced by deaths from degenerative diseases. Furthermore, since the 1960s significant declines in deaths from major degenerative diseases have been noted. This has resulted in significant increases in life expectancy. The

---

[20] Ibid., pp. 9-12.

"very old" group over the age of eighty-five years has increased greatly during the past two decades and is expected to continue into the next century. Some demographers have suggested that life expectancies over one hundred years may be the norm in the twenty-first century. Often cited is the population in the age group seventy-five years and older, the "old older persons". According to census reports, this group is growing at a rate twice as fast as the group aged sixty-five to seventy-four years. This group would tend to have more need of long-term care services, because of the increase in chronic illness and the consequences of the aging process.

Longevity and migration are not entirely responsible for the increase in the size of the population over the age of 65 years. The size of the cohort, represented by the birth rate, that enters the elderly categories fluctuates from year to year, dependent upon the number of births 65 years previous. The birth rate increase which occurred from 1945 to 1965 will create the largest growth in the elderly population between the years 2010 and 2030, barring some unforeseen circumstance which would drastically decrease the entire population. In Michigan, the proportion of the elderly to the population as a whole has not grown as rapidly as it has across the United States. Michigan's birth rate history may help to explain this phenomenon. The increase in births from 44,000 in 1910 to 99,940 in 1927 has caused a steady growth in the population aged sixty-five

years and older in recent years. Between 1927 and 1940 the number of births declined, with the lowest number, 80,500, in 1933. Birth rates increased markedly between 1945 and 1965 and then slowed after 1965. This, coupled with out-migration of the elderly has resulted in a slower growth of the elderly as a percentage of the Michigan population.

Nationally there were an estimated 28 million persons over the age of sixty-five in 1984 according to estimates from the U.S. Bureau of the Census. It is expected that 36.3 million, or thirteen percent of the population of the United States will be over the age of sixty-five by the year 2000. By 2030 that figure will rise to 64.9 million, twenty percent of the population. In Michigan there were 879,919 persons over the age of sixty-five years, in 1980. This was about nine percent of the state's 9.6 million residents. By the year 2030, it is projected there will be 1.8 million persons over the age of sixty-five years, which will be fifteen percent of the state's population.[21] Growth in the group aged sixty-five years and older, while not as rapid as the United States average, is seen as significant over the next forty years. Persons born between 1927 and 1940 will reach the age of sixty-five years between 1992 and 2005, a period of slower growth of the population sixty-five years and older. The "boom" in the elderly population will occur between 2010 and 2030 and then will slow (Figure Four).

---

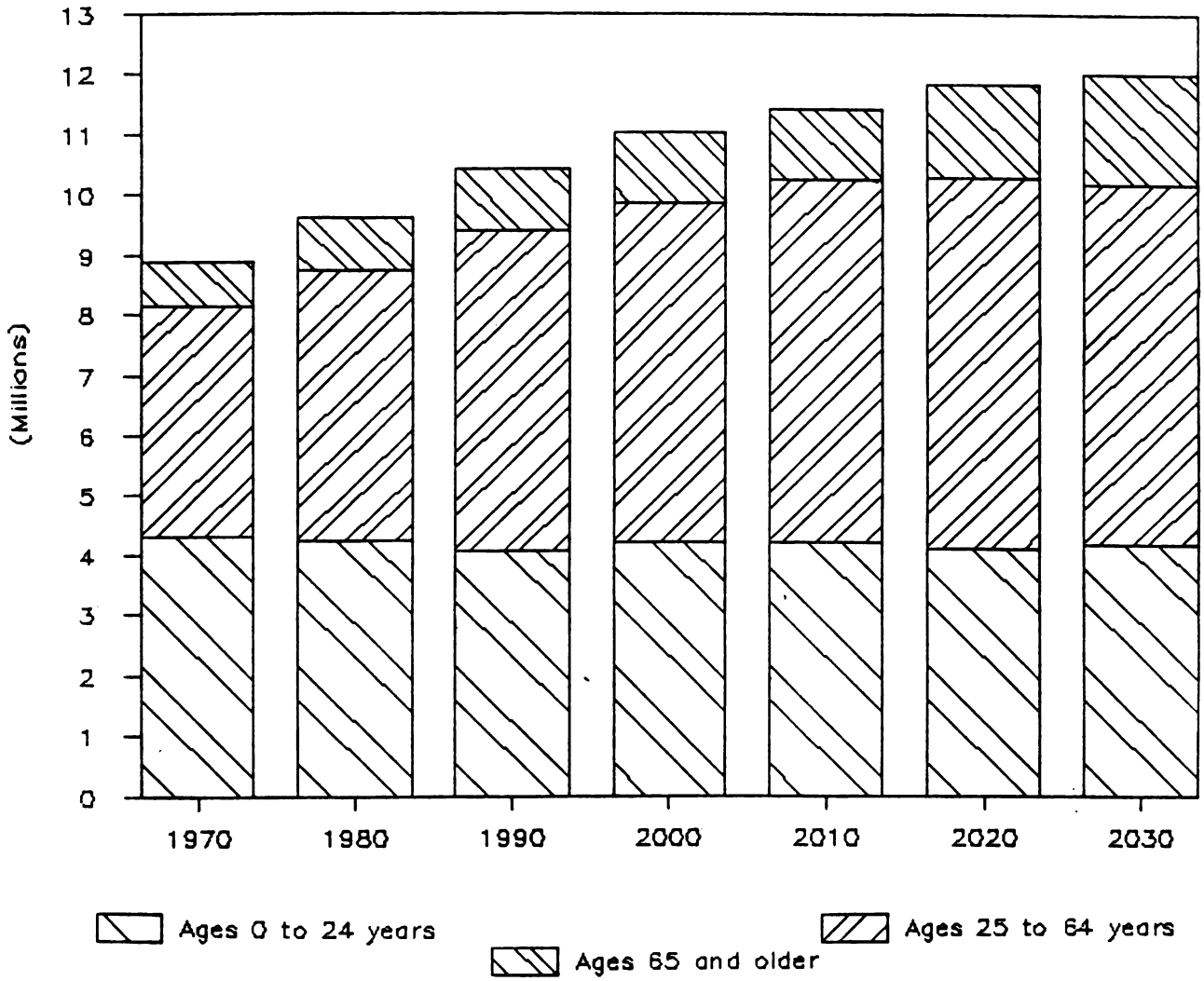
[21] Kurt Gorwitz, "Zero Population Growth, Implications For Michigan", Michigan Medicine, May 1972, p. 14.

A slower growth of Michigan's elderly population compared to the United States is attributed to the fact that in the first half of this century the migration into the state was from a younger age group. Since that time the percentage of elderly in the population has been slightly lower in Michigan than it has been in the United States. This probably means that the impact of caring for an aging population will not be as severe in Michigan as it will in other areas with a higher proportion of elderly. It may also mean that the resources allocated by federal programs on the basis of percentage of elderly will be lower in this state.

The large segment of the population born between 1945 and 1965 has been labeled the "baby boom" and has been compared to a bubble moving through time. This population segment experiences its peak income period between 1975 and 2010. It is during this period that resources for pensions, health care and housing will be most plentiful due to the size of the work force. After 2010 the work force will continue to decline, while the size of the population utilizing pension and health care benefits will expand rapidly. The realization of this fact has caused many to believe that the current Social Security system, financed by taxes on the labor force, will not provide adequate means of support.

Recognizing this, planners of long-term care services are obligated to design cost effective systems which will be in place and maximize available resources by the year 2010. This system has to be based upon an understanding that there

Figure Four



Population Projections for Michigan: 1970 - 2030

Source: Kurt Gorwitz, "Zero Population Growth, Implications For Michigan", Michigan Medicine, May 1972

are various levels of need within the population, and that a continuum of care is a desired goal. Need, therefore, has to be classified and dealt with in a consistent fashion. The personal assessment of need has emerged as a mechanism which resources are matched with people, dependent upon their functional capabilities. The assumption is that only the services needed will be provided at a cost to society (publicly financed assistance). Individual assessment includes a wide range of theories concerning measurement of capacity to function independently.

An underlying belief of comprehensive assessment is that it provides the necessary information that results in the appropriate type and amount of services for those in need. This is done by identifying the characteristics of the patient, including his or her psychosocial support system. The outcome of this process is information which is used to maintain the individual with the maximum level of independence in the least restrictive setting. What is currently considered as comprehensive assessment includes the use of a core, multidisciplinary professional team, with medical and social work skills, using a multidimensional assessment method, generally in the form of a survey known as an assessment tool. Assessment may occur as a result of an elderly client applying for services to an agency providing those services, or it may occur as part of the discharge planning process from an institution providing acute care.

In some states (not Michigan), it is mandated by the government prior to placement in a nursing home.

If a standardized form assessment occurred on a scheduled basis, much like physical examinations, and resulted in a more comprehensive diagnosis and therapeutic intervention, it may serve to close the gap in understanding the loss of function in individuals as a result of disease or as a result of the aging process. This is generally not occurring, because the opportunity for assessment usually is the result of an encounter with the health care system. While physicians will treat disability as the result of disease or accident, some suggest that the physician goes no further in the treatment process if the loss of function is attributed to the aging process.[22]

The value of the resulting data base from a regularly administered, standardized, comprehensive assessment to the health planner is evident. The accumulation of a large data set which identifies and classifies the population by levels of need for services is a necessary first step in any planning process. By determining the functional level of the patient, establishing a level of care needed, and the frequency of that care, it is easy to calculate staffing requirements, or on a larger scale, manpower requirements for health professionals. It is also a more accurate method

---

[22] U.S. Department of Health and Human Services, National Institute of Health, Technology Assessment Conference, Evaluating the Elderly Patient: A Case for Assessment Technology, June 29-30, 1983, Bethesda, Maryland, p. 7.

of determining the need for nursing home beds, short-stay and intensive care hospital beds, and such community-base services as home health care, in a given area.

Common among assessment tools are measurements of the following: physical function and well being; mental and emotional functioning; family/social support; environmental characteristics; the individual's need for specific interventions, therapies and rehabilitation; and the potential of the individual to maintain or improve his or her level of independence. These assessments have been recognized as essential elements of data in the National Minimum Data Set For Long-term Care, published in 1980 by the US Committee on Vital and Health Statistics.[23] That report describes the use of information of this type to: define a central core of data about a given dimension of health and health services needed on a routine basis, and establish standard measurements, definitions, and classifications for this core data.

Widely recognized tools to measure physical functioning capacity include the terms: Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and mobility. The terminology and concepts can be found in literature on physical rehabilitation starting in the

---

[23] U.S., Department of Health and Human Services, National Center for Health Statistics, Long-Term Health Care: Minimum Data Set, Report of the National Committee on Vital and Health Statistics, (DHHS no. 80-1158, 1980) pp. 9-20.

1950s.[24] Dr. Sidney Katz is considered a major contributor to the field of assessment of need among the elderly. Dr. Katz developed an index of Activities of Daily Living through the observation of a large number of patients who had hip fractures, and ultimately tested the index in a large population with multiple medical problems. The result was an index which summarized overall performance in six functions: bathing, dressing, going to the toilet, transferring (from bed or chair), continence, and feeding. Measurement is expressed as a grade between A and G on an alphabetic scale. An "A" grade means maximum independence while a grade of "G" indicates maximum dependence. Measurement also could be classified as "Other" for persons who fluctuated in degree of dependence both upward and downward on the scale. In a clinical trial of 1,001 subjects, Dr Katz showed that this index was adaptable to ninety-six percent of the persons measured who had chronic diseases, or acute problems such as fractured hips.[25] This research was significant in that it provided a measure for the recovery or deterioration of patients in a disease state in terms of their ability to function independently.

The ADL index measures very basic functions, but because independent living involves many additional tasks, an

---

[24] Edith Buchwald-Lawton, Activities of Daily Living for Physical Rehabilitation, New York, New York,: McGraw-Hill, 1952, p. 252.

[25] Sidney Katz, M.D., "Studies of Illness in the Aged," JAMA, 185:12, (September 21, 1963): 914.

additional measurement instrument was developed. This measurement has become known as Instrumental Activities of Daily Living (IADL). This measurement creates a numerical score relating to independence in the following categories: 1) using the telephone, 2) traveling to places out of walking distance, 3) ability to go shopping for groceries or clothing, 4) ability to prepare own meals, 5) do housework, 6) take own medicine, and 7) handle personal finances. The IADL has been adopted by many research projects in the assessment of needs of the elderly, and various numerical scales exist. In general, a higher numerical IADL score indicates a greater degree of independence.

An assessment of mental functioning is understood to be limited to "the extent to which cognitive or affective impairments impede role performance and subjective life quality."[26] This is distinguished from a psychiatric diagnosis in that it is considered to be more predictive of subjective life quality, social relationships, and service utilization. This assessment generally covers cognitive functioning, disturbance of mood, and psychological well-being. Various instruments, including a Mental Status Questionnaire, and the Philadelphia Geriatric Center Morale

---

[26] Barbara Phillips, Issues in Developing the Client Assessment Instrument for the National Long Term Care Demonstration Channeling Evaluation, (Mathematica Policy Research, Inc., Princeton, NJ [1981]), p. 59.

Scale are recognized as valid measurements of mental functioning.[27]

Social functioning is essentially a measurement of social interaction, social support, and a qualitative assessment of social interaction. Social support, in general the availability of an informal care-giver, is usually the most significant information obtained from this assessment. Social support is often measured in terms of what currently is available and what potentially would be available if the patient's needs and services were changed. Several instruments such as Hebrew Rehabilitation Center for the Aged Social Interaction Inventory and the Adult Isolation Index are useful for measuring social functioning.[28]

Measurement of the person's physical environment and living arrangements provides important data on a quality of life perception. Research by Campbell (1976) and by Andrews and Withey (1976) shows correlations between measures of several aspects of the physical environment and a global measure of life satisfaction.[29] Understandably, individual preferences about physical environments can differ, and therefore, subjective (self-perception) measures are at least as, if not more, relevant than objective measures. One instrument which focuses on the physical environments of the elderly living in the community is the Philadelphia

---

[27] Ibid., p. 61.

[28] Ibid., p. 75.

[29] Ibid., p. 103.

Geriatric Center Multi-Level Assessment Instrument. This instrument considers architectural barriers, sense of personal security, convenience, the structural quality of the living unit, satisfaction with the living unit, and satisfaction with neighbors and the neighborhood.

The potential for persons to function independently is essentially an analysis of measures taken in the areas described above. A system, based upon these measurements, permits classification of the individual on the basis of his/her need for services to maintain a standard of living. Grimaldi and Sullivan developed a system of classification for potentially vulnerable people, using four dependency categories.[30] Group one is essentially the younger elderly (sixty-five to seventy-four years) who generally have a living spouse and/or children present providing assistance, but have infrequent need of health or social services. These are classified Independent. Group two, the Independence Threatened group, require high levels of self care from informal care givers and health care providers. This group is considered "at risk" and may experience episodes of intensive care. Those in group three, the Independence Delegated group, generally have a lower health status and limited ability to care for themselves, attributed to their social situation, illness, or the aging process. The ser-

---

[30] Vogel and Palmer, attributed to Paul Grimaldi and Toni Sullivan, Broadening Federal Coverage of Non-Institutional Long Term Care, (Washington, D.C., American Health Care Association, 1981), pp. 3-4.

vices this group requires are often not available in their immediate environment. The persons in group four comprise the Dependent group. These persons are generally in poor health and have very limited ability to care for themselves. They are generally very old (over eighty-five years) with health problems which often require physician or nurse care and frequent hospitalization. Maintaining these persons in their home will frequently require institutionalization in order to provide a respite for the family.

What these assessment processes and classifications provide for the health planner is a data set which identifies the levels of disability for which services will be needed. But unless the assessment process occurs in a standardized, coordinated manner, the health planner may not benefit from it. When assessments are made by third-party intermediaries for the client and the long-term care service, and a data base is maintained, that data is of value in the planning process. Using the model of continuum of care the planner then is able to use this data to determine the impact upon existing services, or perhaps more important, services which are needed in the community to avoid the use of more costly and restrictive institutions.

Physical health and social factors may be considered valuable in maintaining the elderly in the least restrictive environment. But maintaining individuals with varying degrees of health care services has an important cost component. Planning, and ultimately the access to a continuum

of community-based services, is driven by these costs and the means for funding individual care. Because this is a most significant issue with respect to the supply of services, costs of providing and methods of funding long-term care services planners should have a good understanding of funding mechanisms and cost considerations. These are the subject of the next chapter.

Chapter Four: Long-term Care Costs and Funding

As previously stated, the earliest efforts in health planning were for the purpose of budget preparation and capital expenditure. Cost and funding considerations have been, and continue to be, a strong influence upon policy for health care, and particularly for long-term care services. Since the mid 1970s, following nearly three decades of expansion of health care facilities and services, planners and policy makers have been influenced by the impact of costs in providing services.

Embodied in the Comprehensive Health Planning and Public Health Services Amendments of 1966, was the goal to "assure the highest level of health attainable for every person."[31] This was part of the goal of then President, Lyndon Johnson's "Great Society," to use public resources to fill in the gaps of the private sector. According to Sy Berki, "the public programs would ensure that the aged, the poor, and the disabled would be granted access to resources to enable them to enter the mainstream of American medicine."[32]

What followed was an increase in government expenditures for health care. In 1960, for example, twenty-five percent of health care costs were paid for at some level of

---

[31] S.E. Berki, "Health Care Policy: Lessons From the Past and Issues of the Future," Annals, AAPSS, 468, (July 1983): 231.

[32] Ibid., p. 232.

government, and by 1979 this had risen to forty-two percent.[33] The principal factor for this change was the enactment of Medicare (Title XVIII) and Medicaid (Title XIX) on July 30, 1965.

Medicare is primarily an insurance system, funded through employer and individual contributions, and additional tax revenues. It provides benefits under two systems: Part A, Hospital insurance; and Part B, Supplemental medical insurance which pays for physician and other ancillary services. Medicare contains co-payment provisions that require users and their families to pay part of the costs. Over the years, in order to lessen the impact upon federal funds expended under Medicare, the co-payment and deductible (the first expenses, paid by the user) amounts have risen. Medicare was, and remains a significant program for providing payment for acute care services, especially hospital services, to the elderly. It does little towards covering needed long-term care services.

Unlike Medicare, Medicaid is not an insurance program, but is instead a federal grant to states to provide medical care coverage for persons whose incomes and/or assets fall below certain defined limits, set by the states. The federal grant must be matched by state funds, but this matching requirement varies from fifty to seventy percent, with the national average about fifty-six percent.[34]

---

[33] Ibid.

[34] Vogel and Palmer, p. 34.

Medicaid coverage is determined by individual state programs. Michigan is generally considered to have one of the broadest coverage among the forty-nine states with Medicaid programs. Medicaid pays for medical care for the aged who meet Supplementary Security Income criteria established by the Social Security Administration. When a person has coverage under both programs, Medicare is the first payment source for services covered by that program. Medicaid pays any deductibles or co-payments, and, depending upon the state's program, may also pay for the costs of services not covered under Medicare. This is most significant in the area of long-term care, where Medicaid has evolved into the primary public source of funding for long-term nursing home services for the elderly.

Two additional programs which provide resources for long-term care are Title XX and Title III Older Americans Act. Title XX is a joint federal-state program that funds social services. Since implementation in 1974, this program has given states wide latitude in determining social service needs of their specific populations. Under this program, states can provide homemaker (general household tasks), chore (general household maintenance) and personal services (e.g. home health aide, financial counseling) in the client's home. Title III Older Americans Act provides federal funds to the states for similar in-home services. Additionally, Title III provides funds for home delivered meals. Funds available under Title III are allocated to

State Administrations on Aging and the area agencies on aging (AAAs). Each state receiving funds must submit a three year plan to the Administration on Aging at the federal level before funds are released. These programs, subject to budget limitations, are the principal sources of funds for alternative long-term care services.

It is the burden of chronic illness and the aging process which results in high utilization of health services among the elderly. This high utilization is responsible for rising medical costs and resulting cost constraining measures. Studies have shown that persons over the age of sixty-five years (eleven percent of the population) account for approximately thirty percent of all health care spending, and that the source of payment is predominately (sixty-three percent) from government sources.[35] The annual per capita expenditure for health services nationally was $4202 for persons over the age of sixty-five years and $700 for persons under the age of sixty-five years in 1984.[36]

Nationwide there are as many as 1.5 million persons living in nursing homes. Care given to these patients has been estimated to cost $ 3.6 billion annually. As much as fifty percent of these costs are borne by state-financed

---

[35] Charles R. Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review, 1:4, Spring 1980, p. 79.

[36] Daniel Waldo and Helen Lazenby, "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984," Health Care Financing Review, 6:1, Fall 1984, p. 12.

Medicaid programs. The average annual per capita expenditure for nursing home care has been estimated to be $402 for males and $802 for females. Hospital expenditures are even higher. The average annual per capita expenditures for inpatient hospital care are $1,110 for males and $1,090 for females over the age sixty-five years.[37] One response to the increase in hospital costs occurred in 1983 when the Medicare program changed its method of payment from reimbursement for individual services to set prices for specific categories, or medical cases which were termed "Diagnosis Related Groups" (DRGs). Hospitals could no longer charge for a list of services. They instead billed Medicare for treating a disease or disorder and accepted a preset reimbursement. This is a concept known as a prospective payment system (PPS), which establishes a value for medical care based upon a uniform definition. For example, an elderly person in need of a hip replacement would, under PPS, be expected to be hospitalized for a predetermined number of days, with a predetermined number of laboratory tests, a predetermined amount of time in the operating room, and a predetermined amount of physical therapy -- all of which is supplied by the hospital. If a hospital's actual cost is less than Medicare pays for the hip replacement DRG, it is entitled to keep the difference. However, if the hospital's cost is greater, it must absorb the difference. The incentive is for the hospital to keep its costs within the DRG

---

[37] Ibid., p. 14.

reimbursement structure. There is further incentive to avoid patients with a potentially unprofitable DRG diagnosis, particularly obscure, or low volume diagnoses. The implication for long-term care is that patients are more likely to be discharged when their costs reach the allowable DRG reimbursement, irrespective of their state of health. The growth of the home health care industry since the implementation of DRGs provides some evidence that this is occurring. In many states, including Michigan, there are not enough nursing home beds to accommodate the numbers of hospital-discharged elderly still in need of nursing care. Rather than responding to this situation by building or expanding nursing homes, many states have looked to community-based alternatives such as home health care, homemaker, and meals services. These services are costly, and thus far there has not been a nationally supported, comprehensive means of supplying them. This could be partly due to a recognized model for management of these services, but also most probably due to a lack of a national policy on long-term care.

One possible solution to both the management of community-based long-term care services, and controlling the growth of the costs of providing those services, is a mechanism by which the continuum of care concept is implemented. The mechanism should be the tool of an existing agency which is familiar and competent in dealing with the long-term care needs of the elderly. Area Agencies on Aging are such

agencies, involved with coordinating a variety of community-based services, they have initiated a general plan implementation model which has created significant interest at the Federal level. This model, case management, is the focus of the remainder of this thesis.

Chapter Five: Case Management

Long-term care services represent a spectrum of medical and social services which are influenced by the numbers of persons in need of services (demand) and the availability of services (supply). Factors discussed thus far which affect demand are the population at risk, and the assessment of that population's level of disability. Factors influencing supply are the access, or availability of services and their costs. In providing a plan which would address the need for services among the elderly, the health planner must consider methods of implementation. The special circumstances surrounding the elderly's use of long-term care services, e.g. costs, availability, and eligibility requirements, coupled with their generally declining state of health suggest that a mechanism for assisting the elderly client through the maze of services is in order. Case management, a process of assessing need, planning and monitoring the use of services, is one response worthy of attention.

The supply and demand for long-term care services are intertwined, in part because some who would certify a need, physicians, are also providers of services. Access to long-term care services is often through a gatekeeper, which is an individual, process or procedure which evaluates the patient's eligibility to receive the service. Because of this, programs proposing assessment and case management

often emphasize the separation of gatekeeping functions from those of the delivery of services.[38] Physicians, in attempting to provide the best perceived care, protect themselves from malpractice, and ultimately capture whatever third party payment is available, will often over-prescribe for rehabilitative services and/or institutionalize their patients unnecessarily. There are checks built into the system which tend to counterbalance the effect of the physician. First, there is a relatively low use of "high technology" in the provision of long-term care services. Unlike many acute care interventions, long-term care services are more oriented toward nursing care, and this is not generally on a fee-for-service basis. Reimbursement is in fact usually subject to the limits of the Medicare or Medicaid programs, set by DRGs. And finally, because services required go beyond medical care, the physician shares the decision making with other professionals who will determine the patients eligibility, as well as the patient's own support network of family and friends.

This is a departure from the status quo, in which physicians are generally the sole decision makers in the care of the patient. It can be argued, however, that a nurse, especially a geriatric nurse, may be more sensitive to the caring needs of the patient. The social worker, on the other hand, is in a better position to assess the realities and availability of services. Furthermore, both the

---

[38] Vogel and Palmer, p. 28.

nurse and the social worker are likely to have closer contact with the patients and their families. This team is appropriately referred to as the case management team, who share the responsibility for the assessment of the level of care needed by the patient, construction of a care plan, and the coordination of long-term care through referral or direct services.

Case management in its broadest sense can be analogous with many terms associated with the delivery of social services. Protective services, intake, integrated services, client monitoring, and community-based long-term care planning are but a few examples. The concept of case management is basically a recycling of social services concepts dating back to family service agencies from the early 1900's. The purpose of one of these agencies, the Social Service Exchange, was the prevention of duplication of services among agencies which had to stretch resources across a large population in need.[39] One other early effort in this area was in the St. Paul (Minnesota) Multi-Problem Family experiment. This program used planning and service coordination to assist families who had extraordinarily high service needs. This program had as a principal objective the conservation of scarce human service resources through the application of specific implementation strategies.[40]

---

[39] Edna Wasser: Creative Approaches in Casework with the Aging, (New York: Family Service Association of America, 1966), p. 7.

[40] Ibid., p. 11.

Following World War II the federal government funded, for a short time, a program to provide information and referral services to veterans eligible for service connected benefits. This program was one of the first to address the concept of access. By providing information on where to get services, the government expected to aid veterans in their search for programs and services to meet their needs. At this time the government was not greatly involved in intervention on behalf of citizens to facilitate access to health care services. However, there was at this time a great deal of expansion of the health care system with respect to facilities construction under the Hill-Burton Act. The federal government was in a position to know where health services were available, and provide that information to veterans through the Veteran's Administration.

The concept of using a range of services to meet health care needs emerged in the 1950's and paralleled another trend in health care, deinstitutionalization. As the development of drug therapy permitted the return to the community of many from mental institutions, the need for community-based services in varying amounts became evident. Planners and social workers were forced to look to noninstitutional methods of providing needed health and social services to persons who were the residents of "full service" institutions. In evaluating the needs of these persons it was evident that there were varying degrees of abilities in caring for oneself. While some patients needed only oc-

casional assistance with more complex tasks in their lives, others needed daily attention. Home health care evolved as an important response to this need. Home health care was followed by nutrition services which included meals prepared in, or brought into, the home. Recently chore and homemaker services, respite care, and hospice services have become available in the community as a result of public demand for services to meet a wider range of need.

While the underlying concept of case management services has roots in the very beginning efforts of social services, the term and its definition has a more recent history. During the early 1970's the term, "case management" began appearing in the literature. It was during this time that legislation began to separate programs for income maintenance from programs for providing direct services. Several models for a systems approach to service delivery brought forth the idea of coordination and delivery of services.

Brody describes several of these models, which have at their center a means for the assessment of client need, design of a plan to meet those needs, and direction for the client towards the appropriate services.[41] The individuals for this process were termed "programer," "service manager," or "case manager." In addition to the assessment, planning, and referral, the case manager was also responsible for monitoring the results of the plan. This monitoring

---

[41] Ibid., p. 66.

involved feedback from both the client and the providers of services. If additional services were requested that were not in the original plan, these requests would come back through the case manager.

One such model, the American Public Welfare Association Model (APWA), required that an agency maintain an inventory list of specific services, i.e. housing, transportation, and health care, which comprised a system of care. Entry into the system was through a case manager who directed the client to services supplied by the agency, contracted services from outside agencies without cost, or purchased services from providers of care. The evaluation of this model by Rosenberg and Brody revealed that: 1) clients did not request all of the services that were needed, and 2) little effort was made on the part of the case managers to coordinate services not provided by their agencies.[42]

Coincidental to the family service oriented APWA model, models specific for services to the elderly began to appear. These models also included a case management component. Given that case management is multidisciplinary, involving planning and delivery of services, it is an appropriate activity for an agency which has a broad scope of purpose in providing services for the elderly. Such agencies are Area Agencies on Aging (AAA) and state level departments of services to the elderly. Many of these agencies have, through efforts to coordinate services at a local level they

---

[42] Ibid.

were directly providing, adopted an assessment-management-evaluation mechanism which resembled the case management model. These agencies had to create levels of need in their clients in order to appropriately allocate scarce resources. As more community-based services became available, the Area Agencies on Aging have been in the position to identify clients in need of those services, because many were known to the AAAs, having been clients of their services.

As the types of services and the numbers of service providers continue to grow, Area Agencies on Aging have equipped themselves with resources necessary to collect and analyze data, provide planning, and in some case provide direct services for the elderly. These agencies are in the position to direct the coordination of services through case management. The purpose of these agencies may be viewed as the antithesis of the nursing home industry. It is the local Area Agencies on Aging which often see the chronically ill or disabled elderly patient before the nursing home. Programs coordinated by Area Agencies on Aging, particularly those providing meals or homemaker services, bring the AAA personnel into the patients home. There is a strong sentiment among social workers to maintain the independence of the elderly, reflected not only in the literature, but also by the social workers themselves.[43]

---

[43] Interview with Donna Hobart, Tri-County Office on Aging, Lansing, Michigan, July 8, 1987.

Two factors can be attributed to the use of Area Agencies on Aging for demonstration projects in the effectiveness of case management. These agencies were established, and continue to exist to facilitate home and community life for the elderly. As such they have been involved in the location or provision of needed services since their inception. Also, their mission has been to preserve independence in the elderly, according to the individual's means and capacity. These agencies are proponents and advocates of the continuum of care concept. States and the federal government recognized this type of agency to be appropriately equipped and empowered to carry out demonstration projects in case management. The next chapter describes some of those projects which have occurred in this type of agency.

Chapter Six: Demonstration Projects in Case Management

Case management for the purpose of coordinating alternative long-term care service delivery to the elderly is not a new concept to social science. One of the first demonstration projects occurred between 1961 and 1965, in forty family service agencies in thirty-four cities in the United States and Canada. Known as the Project on Aging, sponsored by the Family Service Association of America, the project sought to improve the overall level and quality of case work with clients. This occurred in agencies who were not particularly prepared to deal with the problems of their aging clients. By using a training institute approach, social workers in the Project on Aging expected to: "encourage agencies to reorganize their counseling programs for the aged, to foster experimentation and upgrade services for the aged, and to train staff members in new concepts and techniques for helping older persons."[44]

This project was significant in that it focused on the special needs of the elderly client, and teaching the family service caseworker techniques in identifying and meeting those needs. This project further stressed the caseworker's role in helping the clients adapt their environment to their functional ability, or assist in the clients' adaptation to their environment, or, failing these, move clients

---

[44] Wasser, p. 91.

to a new environment. This project further discussed the issue of costs of providing alternative services:

> Because the aged client is more likely to require more home visits, more interviews, a larger number of services, and perhaps a longer period of casework contact, the cost of helping him effectively is likely to be high. But the cost of providing whatever services the aged client needs to enable him to remain in his usual setting must be weighed against the cost to him and to the community of placing him in an institutional setting. In addition, cost in money should be measured against the emotional cost to the aged person and his relatives of either keeping him or making arrangements for him to live in another setting.[45]

The Triage model was a single state demonstration project that was initiated in Connecticut in 1974. This model targeted an eligible population of about 20,000 people aged 65 and older, living in a seven town area of central Connecticut. This program's design provided a single point of access to the health care system, with a liaison that coordinated services for elderly and disabled persons. The target population was Medicare eligible, but service delivery was developed around assessment of need rather than being tailored to fit existing reimbursable sources. Originally funded through state funding and a grant from the Federal Administration on Aging, the program was renewed in 1979 with funding from HCFA, using Medicare waivers which allowed for the diversion of Title VIII money to the program to pay for services not usually covered by Medicare.

---

[45] Ibid., p. 29.

The stated objectives of this project were:

> 1) To increase the effectiveness of health services; 2) to develop necessary preventative and support services and demonstrate their value to the target population; 3) to provide a single entry, assessment mechanism to coordinate delivery of institutional, ambulatory, and in-home services which result in cost containment; 4) to demonstrate the effectiveness of coordinated care, including: a) care to prevent illness, compensate for disability, and support independent living at home, b) care prescribed to answer need rather than to accommodate third party payer service restrictions, and c) use of professional nurse clinician/social service coordinator teams to assess needs of individuals, arrange for appropriate services, and provide case management; and 5) to reduce expenditures for health care delivered to the target population.[46]

In the Triage model an interdisciplinary team, consisting of a nurse-clinician and a social worker developed and monitored a clinical process of care consisting of referral, assessment, coordination of the care plan, and evaluation. Referrals were from family, friends, visiting nurses, hospital staff, social workers, or the clients themselves. The team visited the client's home and fully assessed need, using a comprehensive assessment form. This assessment included a modified physical examination; a complete health history; information on functional status, nutrition, and physical environment; and an informal support system. The assessment provided a baseline of data upon which the plan of care was developed. The care plan was developed by the Triage team, who worked with the client and his or her family to select services which were appropriate to the

---

[46] U.S. Department of Health and Human Services, Administration on Aging, Statistical Reports on Older Americans, Some Prospects for the Future Elderly Population, (Washington, D.C., January 1978), p. 16.

clients needs. After service delivery commenced, the Triage team maintained ongoing contact with the client to ensure that services continued to be consistent with the care plan in terms of quality and quantity. In addition, the team consulted frequently with the providers of services, met on a regular basis with home health agencies in the region, and met with other service providers as needed. A medical team, consisting of five physicians, two dentists, a podiatrist and a pharmacist served as an advisory committee, available for consultation to the Triage team.

In the evaluation of the Triage project, data indicate that seventy-two percent of the participants improved or maintained their ability to conduct activities of daily living. However, the overall performance of the participant group on the assessment scores decreased with advancing age. The total cost per participant for 1978 was $3,620, or an average daily cost of $12.63. This program was very popular, and as a result a lengthy waiting list developed. Because of the success of the demonstration the Triage project evolved into Connecticut Community Care, Inc., which is a statewide, non-profit, partially state-supported corporation.

A second model using central assessment and care plan development was used in a demonstration project by the Monroe County (NY) Long-term Care Program, Inc. (MCLTCP). The project defined the Assessment for Community Care (ACCESS) model which was responsible for all aspects of

long-term care. The project was targeted at residents of the county who had long-term care needs and whose services were covered by the state's Medicaid program. The stated purpose of the demonstration "is to demonstrate alternative approaches to delivering and financing long-term care to the adult and elderly population of Monroe County."[47] The objectives of the MCLTCP project are:

> 1) To provide long-term care services which are appropriate, cost effective, and acceptable to the client; 2) to provide coordination and continuity of case management for long-term care clients; 3) to improve long-term care assessment and review procedures; 4) to collect data about needs, service utilization, and appropriateness of placement on persons requiring long-term care; 5) to reduce the number of residents who are in acute care hospital and long-term care institutions; and 6) to reduce the per person rate of increase of Medicaid expenditures for individuals in need of long-term care from what it had been had the project never existed.[48]

According to one analysis the stated objectives were in response to long-term care services which were described as fragmented, in terms of regulation, financing, and organization of the long-term care system. "The key to any reallocation of public resources in long-term care is the development of a mechanism to overcome the rampant fragmentation so that persons in need of care can enter the system in a timely fashion and be served in the most appropriate, least costly setting."[49]

---

[47] G.M. Eggert, et al, "Gaining Control of the Long Term Care System: First Returns from the ACCESS Experiment," Gerontologist, vol. 20, p. 356.

[48] Ibid., p. 357.

[49] Ibid.

The method of implementation of the program objectives was through a five step process: 1) casefinding, initiated through referrals from hospitals, other providers in the community and the client's family; 2) assessment, based upon a four page Preadmission Assessment Form (PAF) which recorded demographic data, medical data, functional status indicators, family support information, and a description of required therapies; 3) determination of level of care, a case management system which maintained continuing contact with the client and institutions or providers of service; 4) service plan development, which was designed for clients who would not be institutionalized, but would require home health services; and 5) continued monitoring and reassessment of clients placed in nursing homes or receiving home health services, to ensure that the care provided was medically necessary, and adjusted if needed.

The program facilitated the provision of services to more than 9,500 clients between 1977 and 1981. During 1981 intake and assessment "averaged 390 per month with 70% of the referrals being made from hospitals and 30% from non-hospital sources."[50] Overall the program showed that forty-six percent of the clients referred from non-hospital sources needed skilled level care, and eighty-nine percent of these clients could receive that care in their homes. For clients referred from hospital sources, seventy-six percent needed

---

[50] Gerald M. Eggert, "The ACCESS Process: Assuring Quality in Long Term Care," Coordinated Service Delivery Systems for the Elderly, New York: Haworth Press, p. 42.

skilled level care, and thirty-six percent could receive that care in their homes.[51] The data supplied over the period of the demonstration showed a trend of improvement in maintaining or returning clients to their homes, and provided clients with choices of where they would like to receive care, that is, in their community or in an institution.

Reports indicate that the ACCESS program achieved the objective to decrease the growth of Medicaid expenditures for long-term care clients. During the time of the demonstration program the Medicaid population in Monroe county experienced a growth of nine percent, compared to a growth in adjoining counties of between minus ten percent and plus ten percent. The increase in total Medicaid expenditures for long-term care recipients was thirty percent, compared to increases of thirty-five percent to forty-nine percent in adjoining counties. Substitution of home health care for institutionalization is offered as an explanation for the slower increase in Medicaid expenditures. The ACCESS program showed an average in home cost of $25 per day, compared to a $50 per day cost in nursing homes.

Medicaid costs did decrease for long-term care recipients as a result of ACCESS. However, there were additional costs to the long-term care system. These costs are attributed to the costs of case management and monitoring activities. Overall the average cost per client, per year, was $346. The range of costs were between $411 for clients

---

[51] Ibid., p. 44.

referred to home care from a non-hospital source, to $238 for clients referred to nursing home care from a hospital source. The difference can be understood in that clients cared for in their own homes would require and receive more attention from the case management team, than would clients in nursing homes.

Costs of case management notwithstanding, this project is considered a successful demonstration of substituting home health services for nursing home services. The results of the project were convincing in that another demonstration in Monroe County began in 1982, with an expanded model which included Medicare eligible patients. This project also includes expanded services into the areas of financial counseling, in-home architectural review and transportation services.

As a result of the successes of these and other demonstration projects, and in recognition of alternatives to nursing home services, the National Long-term Care Demonstration, known as "Channeling," (directing towards appropriate resources) was initiated by the United States Department of Health and Human Services in September 1980. Three units within HHS -- the Office of the Assistant Secretary for Planning and Evaluation, the Administration on Aging, and the Health Care Financing Administration -- were responsible for the design and implementation of this project.

Channeling was designed to use comprehensive case management to allocate community services appropriately to

the elderly in need of long-term care. The specific goal was to test a system of community-based, long-term care services which would allow elderly persons to remain in their own homes. Case management, care planning, and the delivery of health and social services were provided to determine their potential role in controlling the costs of long-term care while maintaining or improving the quality of the client's or the care giver's lives.

Two models of Channeling were tested: 1) a Basic Case Management model used coordinating and monitoring mechanisms within an existing system of community services; and 2) a Financial Control model, which extended the Basic model to provide resources for direct purchase of services, thus assuring access to services.[52]

Case management, the primary component of each model, consisted of seven features.

1. Outreach to identify and attract potential clients who were at risk of entering a long-term care institution.

2. Standardized eligibility screening to determine whether an applicant met the following pre-established criteria:

   Applicants had to be sixty-five years or older;

   Applicants had to have two moderate disabilities in performing activities of daily living (ADL), or three severe impairments in ability to perform instrumental activities of daily

---

[52] U.S. Department of Health and Human Services, The Evaluation of the National Long Term Care Demonstration: The Planning and Operational Experience of Channeling Projects, (Princeton, New Jersey: Mathematica Policy Research, Inc., 1986), pp. 14-15.

living (IADL), or two severe IADL impairments and one ADL disability.

Applicants had to have an unmet need, for two or more services or an informal support system in danger of collapse.

Applicants had to be living in the community, or if institutionalized, certified as likely to be discharged within three months.

3. Comprehensive in-person assessment to identify individual client problems, resources, and service needs in preparation for developing a care plan.

4. Initial care planning to specify the types and amounts of care required to meet the identified needs of clients.

5. Service arrangement to implement the care plan through provision of both formal and informal in-home and community services.

6. Ongoing monitoring to assure that services were appropriately delivered and continued to meet clients needs.

7. Periodic reassessment to adjust care plans to changing clients needs.

The Basic Case Management model tested the hypothesis that "the major problem in the current long-term care system was lack of information about, and coordination of services already existing in the community; and that these problems could be overcome by client-centered case management."[53] This model provided a financial resources to purchase services to fill in gaps of existing community programs, but generally relied on what was already in place.

The Financial Control model differed from the Basic model in several ways. The range of community services was more extensive in that services were created to meet needs

---

[53] Ibid., p. 12.

if they did not exist. The use of funds was to insure services on basis of need rather than eligibility criteria. Case managers were empowered to authorize services for clients, and thus many more persons would be expected to receive services. Expenditures were limited to 60% of the aggregate nursing home costs, so as not to exceed nursing home expenditures, without special approval. Finally clients were required to share costs if their income exceeded 200% of the state's eligibility level for welfare benefits.

Site selection for the channeling project was based upon interest at the state level, capacity for case management functions, and whether channeling would represent a change from the existing system. A project was selected representing the basic model or the financial control model in the following areas: Baltimore, Maryland; Houston, Texas; Middlesex County, New Jersey; eastern Kentucky; York and Cumberland counties in Maine; Miami, Florida; Greater Lynn, Massachusetts; Rensselaer County, New York; the greater Cleveland area of Ohio; and Philadelphia, Pennsylvania. Hawaii and Missouri were originally selected as part of the demonstration project, but later dropped from the evaluation for budget reasons.

The projects began operations between February and June of 1982, continued full operations through June of 1984 and were phased out by March of 1985. Many projects continued to operate under state funding or other resources. There

were 6341 elderly persons randomly assigned to the two channeling models at the ten channeling sites. Research samples used in the final evaluation for various parts of the channeling project ranged in size from 3372 to 6326.

Data for the evaluation of channeling programs came from a variety of sources. Screening of applicants for the channeling project was performed using telephone interviews. In-person surveys were used to obtain data from the elderly participants in either of the sample groups at the onset of treatment and at six-month intervals for the following eighteen months. Telephone surveys with the informal care-givers occurred at the onset of treatment and at six and twelve months afterward. Cost data was supplied by Medicare, Medicaid, channeling site records, and from providers supplying direct services. Federal, state, and local Channeling project staff was interviewed about the implementation and operation of the demonstration.

The two models described were expected to affect four areas: use of community-based services; placement in nursing homes; hospitalization; and quality of life, expressed in terms of physical and psychological well being of the client, and factors influencing care-giving by family and friends. It was expected that savings from the reduced use of nursing homes and hospitals would offset extra costs from increased use of community-based services. Furthermore, case managers expected to limit increases in community-based

service costs by working with informal care-givers to help them continue to provide care.[54]

Evaluation included a measure in differences between the two treatment models. The Basic Case Management model was designed to test the premise that major difficulties in getting appropriate long-term care in the community is lack of information about the services and the inability to obtain and manage services under the existing system, not lack of financing for those services. The Financial Control model assumed that inadequate financing of community service leads to inappropriate use of nursing homes, and that added resources to community-based programs beyond the core Channeling functions would reduce the costs of long-term care, steering people toward community programs and away from institutions. Both models contained three elements of case management: problem identification, information and advocacy and support, which were intended to facilitate the substitution of community services for institutional services. The functions of initial needs assessment, ongoing monitoring and periodic reassessment allowed case managers to identify serious health problems and mismatches between client's needs, services and service providers. Case managers could act to correct any problems by advocating for the client. The case managers also were a source of

---

[54] U.S. Department of Health and Human Services, The Evaluation of the National Long Term Care Demonstration: Final Report, (Princeton, New Jersey: Mathematica Policy Research, Inc., 1986), p. 7.

emotional support for clients and their informal care-givers.[55]

Major findings from the program include the following:

The population served by Channeling was extremely frail, had low incomes and reported many unmet needs. The average age was 80 years, the average income was $542 a month, and 84% were restricted in their ability to perform activities of daily living (ADL). The remainder, while having no ADL impairments, had multiple impairments with respect to the Instrumental Activities of Daily Living (IADL).

Channeling's comprehensive case management services were implemented largely according to plan for the treatment group, but a substantial minority of the control group also received case management from other sources.

Channeling substantially increased the receipt of formal community services; this increase was particularly noteworthy in the financial control model.

Channeling did not affect mortality rates under either model (although no comparison was made with non-channeled clients).

There is no evidence that Channeling led to substitution of formal for informal care in the basic case management model. There was evidence of some substitution in the financial control model. However, it did not result from decreased efforts by primary care-givers, but rather from reductions in care-giving by some friends and neighbors.

Channeling led to an increase in the total subsistence, medical and long-term care costs per client over the observation period. The basic case management model appeared to increase these costs by about $1500 per client or approximately 8% above the $18,000 in costs that would be expected without Channeling. In the financial control model, the cost increase was $3500 or 16% over the $23,000 that would otherwise be expected.

Channeling did improve the well-being of care givers by some measures, especially in terms of satisfaction with service arrangements and overall life satisfaction.

---

[55] Ibid, p. 8.

> Channeling reduced reported unmet needs, increased confidence in receiving needed services and increased satisfaction with service arrangements for clients. There were small but generally beneficial effects on social and psychological well-being.[56]

An analysis of these findings indicate that the outreach component of the project was successful, even when other programs, such as hospital discharge planning, existed to assist clients in accessing community services. The finding that Channeling led to an increase of formal community-based services (especially in the Financial Control Model) suggests that there were a significant lack of alternative forms of service in existence and when funds became available, service delivery mechanisms were created to meet the need. Channeling reports indicate that respite care and special equipment assistance were two such services affected. The extra costs for these services, and the costs of case management, were not recovered through a decrease in nursing home use. Criticism of the Channeling demonstration seems to focus on this fact. The per-person savings reported for the Basic Care model were $280 over an eighteen month period, and $120 for the Financial Control model. These savings offset only about ten to twenty-three percent of the costs of providing case management.[57] Furthermore, the results of this project are consistent with those of other community care demonstrations, particularly that "populations served had relatively low risk of nursing home

---

[56] Ibid., p.7.

[57] Ibid., p. 59.

use...and [programs experienced] insufficient cost savings to offset the increased costs of expanded case management and community services."[58]

The claim that Channeling did not benefit the "at risk" population warrants further investigation. A comparison of the demographics of Channeling clients with a nationwide survey of nursing home residents revealed that forty percent of nursing home residents were over the age of eighty-five years, compared to twenty-eight percent of the Channeling clients. Also thirty-two percent of the Channeling clients were married, compared to twelve percent of the nursing home residents. And finally Channeling clients had better ADL scores in eating, toileting, dressing, and bathing compared to nursing home residents.[59] While the project did not show significant results in avoiding placement in nursing homes, there was one group of clients in a nursing home at the time of prescreening. This group, which was only three percent of the entire Channeling population, had between a twenty-five and thirty percent reduction in nursing home use. This suggests that Channeling had resulted in returning clients to the community, if they were in a nursing home at the time they were admitted to the demonstration project.

The program has not greatly reduced the role of the informal care giver, indicating that the additional benefits of the program have not supplanted the clients family or

---

[58] Ibid., p. 18.

[59] Ibid., p. 49.

friends as resources for care. The project reported that care-givers provided two and one half hours a day of care for clients in the Basic Case Management model, and three hours a day of care in the Financial Control model. Measurements at six and twelve months showed no significant difference in the time contributed by the informal care-givers, even in the presence of expanded formal services.[60]

The reports of the evaluation of the Channeling project indicate that results were consistent across the demonstration sites for each of the models tested (indicating that it was unlikely that one of the demonstration sites would dominate the results of the research). Evidence of the impact of the demonstration project may be found in the fact that all of the demonstration sites, as of December 1986, had continued (without federal funds specific for case management) their case management functions as a part of their local long-term care system.

One additional effect of this demonstration was an increase in attention given to case management and use of alternative, community-based services by those who work toward providing the elderly with access to need health and social services. The great deal of planning that went into the design and implementation of this demonstration project contributed to the knowledge and understanding of case management as a mechanism for providing a continuum of care.

---

[60] Ibid., p. 106.

In Michigan, shortly after the start of the Channeling project, the Office on Services to the Aging began a pilot project which employed a case management model in client assessment and service delivery. From this pilot, an expanded, statewide demonstration project, known as the Michigan Care Management Program, emerged. The following chapter looks at that statewide project.

Chapter Seven: The Michigan Care Management Program

In 1983 the Office on Services to the Aging in Michigan initiated a pilot program throughout the state to "find, mobilize and manage a variety of home care and other services needed by frail elderly persons aged 60 and older at risk of entering a nursing home."[61] This program, known as Care Management, is built around a centralized comprehensive assessment, care plan development, management of that plan, and continuing monitoring/reassessment of the client's progress and program costs, utilizing a care management team. In addition, this program has several features setting it apart from demonstration projects discussed thus far.

> Service Brokering - Direct services for client care are brokered, i.e. supportive health care and social services are arranged and/or purchased according to the frequency and duration established by care managers and approved in care plans. Client centered advocacy is conducted to ensure access to, and appropriate utilization of, community services.
>
> Social/emotional Support - Provided by care managers to clients and their families to facilitate life adjustments and bolster informal support. Family case conferencing is conducted as necessary.
>
> Identification of unmet client needs - Care managers document services not currently available to meet the needs of clients for AAA planning purposes.
>
> Advocacy - Provided by care managers to assist clients and their families to gain benefits and services that the client is entitled to. Care managers assist in

---

[61] Michigan Office of Services to the Aging, Draft Care Management Standards, (Lansing, Michigan: Office on Services to the Aging, 1987), p. 1.

accessing Medicare/Medicaid and other third party benefits and services.[62]

The project was designed for 750 clients to be served at twenty-two sites across the state. The target population was persons 60 years and older who were at risk of nursing home placement based upon one or more of the following:

1. Determined medically eligible for placement into a basic or skilled care nursing or foster care facility; or

2. Functionally unable to provide self-care without assistance due to illness or declining health and without sufficient support for meeting care needs; or

3. Multiple, complex and diverse service needs; or

4. Currently resides in a skilled or intermediate care facility or other institution and no longer requires this level of care, but because of insufficient resources and lack of other supports is unable to obtain needed community services to return home.[63]

The state Office on Services to the Aging has provided grant support to Area Agencies on Aging (AAA) for pre-screening, assessment, care plan development, management, and monitoring. The AAAs may subcontract these services but are ultimately responsible for maintaining program standards. The program maintains standards to avoid conflict of interest with Care Management agencies, avoid duplication of services, use only qualified and trained staff to serve clients and preserve the rights of the clients to self determination. Participating agencies also

---

[62] Ibid., p. 3.

[63] Ibid., p. 4.

must maintain the client's privilege of confidentiality regarding written or oral communications.

The agency responsible for Care Management develops referral agreements with hospitals and other community-based agencies. Because Care Management is a source of services for eligible clients, most hospitals enter into referral agreements even though it may duplicate their own efforts in discharge planning. The Care Management agency prescreens referrals using a standardized form, the Prescreening Tool (Appendix A). The purpose of prescreening is to establish baseline health, social, emotional, and environmental needs, and determine eligibility for enrollment in Care Management. It also evaluates the current level of care provided (by informal care givers) and whether that level of care will continue or additional assistance is needed.

Eligible clients receive a comprehensive assessment using a form known as the Client Profile (Appendix B). This assessment provides in depth information on family and household status, physical health, activities of daily living, social/emotional status, social relationships and support, physical environment, and economic status. Questions are asked of the client by a team, including a social worker and a registered nurse. The information gathered during this assessment process provides information about the client's perception of health status, autonomy and social needs, as well as financial resources and living arrangements. The assessment gives close attention to

utilization of formal and informal health and social services. Questions in this area are intended to identify gaps in the local service delivery system and referred to in monthly reports prepared by the local Care Management Agency to the Office on Services to the Aging for future planning purposes.

Within five days of the comprehensive assessment a plan is developed by the care management team, the client and the client's family or others as appropriate. This plan responds to the findings (problems) of the comprehensive assessment. The plan identifies needed services, including the frequency and duration of those services. The plan further identifies providers of services, costs and sources of payment of those services. In constructing the plan the Care Management team brokers for services, orders services, and maintains records of service delivery. If Care Management advocacy, counseling or family case conferencing is required, the plan reflects this as well.

With the implementation of the Care Management plan the team assumes responsibility for follow-up and monitoring of service delivery. The Care Manager contacts both clients and providers to assure that services brokered are timely, appropriate, and meet standards of quality. Contact is made within two weeks of plan development. If changes in the service plan result from the monitoring process, those changes are recorded by the care manager.

Care Management clients are reassessed within 90 days of the original comprehensive assessment, or any follow-up assessment. The purpose of reassessment is to identify changes in any of the assessed areas, e.g. physical health, social support. This reassessment also measures the progress toward meeting the goals outlined in the care plan. A client's status in Care Management may change following reassessment from active to inactive.

The Care Manager designates case status for all clients, which defines the extent of Care Management intervention. This determination of status first occurs during the care plan development process and continues with each subsequent comprehensive assessment. Case status can be active, inactive or closed. Active cases require the most attention, and reassessment occurs every ninety days. Inactive cases require less frequent monitoring for several reasons: the client is stable and adjustment in the care plan is not anticipated for four to six months; the client has refused services, but care managers believe services may be accepted within four to six months; or the client is institutionalized and may be returning home within the next four to six months. Closed cases may result from client-initiated withdrawal from the program, client improvement or stabilization, permanent institutionalization, or death.

By July 1987, the process of analyzing the Michigan Care Management Program was not completed. There is an analysis of a preceding pilot that suggests some of the

potential outcomes of the Care Management demonstration. In 1983 a single program in St. Joseph, Michigan (Region 4 of the Area Agency on Aging), was set up to test the care management model, as described above. The analysis of this demonstration looked at the impact of care management in five areas of the patient's life and environment: health, security and daily care; financial matters; routine home maintenance; and basic equipment use. That analysis found:

> Statistically significant beneficial differences for those high risk elderly receiving care management, in comparison to those receiving services normally provided in the community, were evident in seven of the twenty variables measured between initial baseline interviews and the second interviews which occurred 15 months following the first.[64]

Compared to the control group, the ninety-five clients in the care management group had approximately twenty-five percent fewer in-patient hospital admissions, thirteen percent fewer emergency room visits, twelve percent fewer nursing home placements, and six percent fewer foster care placements. This trend continued at an interval of twenty-one to twenty-five months following the initial baseline interview. At that time, compared to the control group, there were twenty percent fewer in-patient hospital admissions, forty-four percent fewer emergency home visits, nine percent fewer nursing home placements, and five percent fewer foster care placements.[65] Unfortunately the results

---

[64] Michigan Office on Services to the Aging, Executive Summary, Research Report on Care Management, (Lansing, Michigan: Office on Services to the Aging, 1986), p. 1.

[65] Ibid.

of the last assessment were not significant, "due to the high attrition rate (mortality = 74%) among the original sample group."[66]

According to Pam Graves, Long-term Care Coordinator for the Michigan Office of Services to the Aging, early data from St. Joseph and other demonstration sites indicate that care management has not resulted in prolonged life for the client. The Office of Services to the Aging does feel, however, that because of a well established "positive correlation between reduced utilization levels and a reduction in health care costs...the continuing reduction [of utilization of services] established by this research will show substantial savings in public health care dollars."[67]

From the other demonstration sites participating in the Michigan Care Management there are other preliminary results worth noting. One of the requirements of the participating sites is the preparation of monthly reports for use by the Office on Services to the Aging. One report, the Care Management Monthly Report, includes a section for reporting gaps in services in the community (Appendix C). This report describes services in seven areas of health, social support and environment which are not available, unaccessible due to cost or waiting lists, or frequency of service is inadequate. This report results in a focus on community need by

---

[66] Ibid.

[67] Interview with Pam Graves, Michigan Office on Services to the Aging, Lansing, Michigan, June 30, 1987.

the care manager. Mary Baker, Care Management Coordinator for the Community Action Agency in Sault St. Marie, Michigan, has submitted a proposal to the Kellogg Foundation requesting funding to build and staff a rural health clinic to serve the needs of the elderly in a three county area of Michigan's Upper Peninsula. As a result of Ms. Baker's efforts in identifying needs and providing services for 29 clients in Care Management, cooperative agreements have been reached with the nursing program at Lake Superior State College. These student nurses have participated as part of the care management team, by visiting the elderly in their homes, performing assessments and providing services. The proposal to the Kellogg Foundation for $372,000 over a three year period will provide a facility, equipment, and staff support for a health clinic which ultimately will be a service provider in the care management program for Mackinac, Chippewa and Luce Counties in Michigan. It is the assumption of this proposal, and of the care management program in this area, that the provision of nursing services in a noninstitutional setting will result in a decrease in hospitalization.[68] Furthermore, care management in this area has resulted in important linkages between a community service agency and a school of nursing. Given that health manpower is often a critical issue in planning for the delivery of long-term care services, the benefits of the

---

[68] Telephone interview with Mary Baker, Chippewa, Luce and Mackinac Human Resource Authority, Inc., Sault Ste. Marie, Michigan, July 13, 1987.

efforts in Sault St. Marie to utilize nursing students in care management warrant further investigation.

An additional demonstration site has provided useful information for analysis of the Michigan Care Management program. The Tri-County Office on Aging, participating as a care management site for Clinton, Eaton and Ingham counties in central southern Michigan, recently surveyed clients and providers of services. The purposes of these surveys were to: 1) better understand the impact of care management upon community agencies providing services or making referrals to care management, and 2) obtain information on client satisfaction with care management and community services received through care management.

According to Donna Hobart, Care Management Director for Tri-County Office on Aging, the surveys were initiated as a result of their interest in determining community and client impact two years following the implementation of the program.[69] Among the significant findings from the agency survey were the following:

> The need to increase Care Management services for the elderly population in the Tri-County area is evident. Care Management represents an alternative approach to the fragmented long-term care based on the medical model.
>
> Care Management is an effective method of identifying and meeting service gaps because it has an overall perspective.
>
> Care Management addresses the needs of the elderly population with complex and severe needs and are at

---

[69] Interview with Donna Hobart, July 8, 1986.

> risk of institutionalization. The program can relieve the excessive burden placed on families.
>
> The availability of services in the Tri-County region is an ever increasing problem, besides the lack of coordination. Care Management identifies high risk individuals to target for services, and directly pays for those services in the event the client's resources will not cover them.
>
> Care Management has the particular problem of separating the impact on clients caused by Care Management itself, from the impact of the community services provided as indicated in the care plan.[70]

Findings from the client's survey showed:

> The Care Management program seems to be doing a good job of assisting clients by assessing needs, obtaining and monitoring in-home services. These services are adequately meeting the needs of most of the survey respondents. And the services provided of greatest significance were home delivered meals, transportation, companions, health aides, and homemaker services.[71]

An additional finding of both reports was the need to increase Care Management staff in order to respond to clients and providers in a more timely manner. Tri-County's Care Management program currently has an active caseload of sixty-five and an inactive caseload of thirty. There is only one care management team consisting of a nurse (BSN) and a social worker (MSW) to do the assessments and follow up visits.

According to Ms. Hobart, the program's success has also been its greatest problem. There are more people requesting

---

[70] Tri-County Office on Aging, Care Management Evaluation: Agency's Report, (Lansing, Michigan: Tri-County Office on Aging, May 1987), pp. 12-13.

[71] Tri-County Office on Aging, Care Management Evaluation: Client Survey, (Lansing, Michigan: Tri-County Office on Aging, June 1987), pp. 13-14.

services than can be accommodated with the current staffing level. A waiting list for care management services exists and clients can anticipate as long as thirty to forty-five days before they can be assessed in order to develop a care plan. Half of the referrals (fifty-one percent) for the Care Management program come from the clients family, another twenty-four percent come from home health agencies who are generally utilized for a period of time following hospitalization of the client, and the remaining referrals are from family, physicians, nursing homes or other community agencies.[72] Referrals result from public awareness of the range of service provided by Care Management programs. This would indicate that Care Management is meeting a need within the community to facilitate long-term care services in a noninstitutional setting. This further indicates that this model of case management is achieving a degree of success with the implementation of a continuum of care concept within the long-term care system.

Another impact that this model of case management may have on the health care system is potential for adding additional clients to public assistance programs through advocacy. Currently there is anecdotal evidence offered by the Tri-County Office on Aging and the Michigan Office on Services to the Aging which suggest clients who were unsuccessful in obtaining public benefits before they were in a Care Management Program, did receive benefits as a result of

---

[72] Interview with Donna Hobart.

advocacy on the part of the care management staff. A fully operational, statewide Care Management program could result in an increased number of persons receiving public benefits. While these persons would be fully entitled to these benefits, an increase in the numbers of clients on programs such as Medicaid or Supplemental Security Income assistance would have implications for health care resource. The potential impact of the advocacy component of the Care Management program warrants further investigation.

Additional research on the impact of Care Management upon the quality of care received by the client is also indicated. Care Management directly purchases some services for their clients, brokers for other services, and monitors all services on an ongoing basis, and thus it has both the ability to determine and the leverage to impact the quality of care given to the client. Particularly with home health services, where the number of providers are increasing and competition for clients is being noticed, Care Managers are in the position to evaluate the quality of the service and select providers who meet a standard of care. It is too early to tell what influence Care Management will have over the quality of community-based services. However, if the majority of elderly in need of services were in the Care Management program, it is likely that data relative to quality of care and resulting discussion over standards of quality would receive attention similar to that which is currently given to the costs of health care services. At a

minimum, a standard of measurement of quality would be possible if a statewide Care Management program were in place.

If demonstration projects such as the Michigan Care Management Program are judged successful, one might expect additional action in areas of policy and legislation. A demonstration, by its definition, should provide useful information to planners and policy makers who deal with those issues. With respect to the Michigan Care Management Program, two subsequent activities at the state level point to the recognition this project has received.

The Statewide Health Coordinating Council (SHCC), the state's health planning body within the Department of Management and Budget, has appointed a task force to look at long-term care services and needs and make recommendations back to the SHCC. In a report, released in June 1987, twenty-three recommendations were made to address eight problems in the area of long-term care. Recommendation F3, regarding enhancement of existing services is as follows:

> Care/case management services should be made available to persons with multiple and complex long term care needs involving a number of different agencies. Such programs should be client centered, cost effective, not detract from funding for direct services, and not eliminate client choice.[73]

---

[73] Michigan Department of Management and Budget, Office of Health and Medical Affairs, Report of the Task Force on Long Term Care to the Statewide Health Coordinating Council, by John Herrick, Chairperson, (Lansing, Michigan: Office of Health and Medical Affairs, July 16, 1987), p. 40.

Rationale for this recommendation included:

> A major goal of case management is to help the individual and his or her support system to negotiate the complex service delivery system. Individuals with multiple and complex long term care needs may require numerous services provided by many different agencies. Case management can help to ensure that all of the client's needs are properly met.[74]

This report proceeds to recommend that the SHCC establish an on-going committee to monitor and assess long-term care policy, programs and issues. This committee would make recommendations to the planning body on a timely basis. This would also establish a forum for discussion of long-term care issues, and assist the planning body in its response to the long-term care system.

A second activity in direct response to the Care Management project was the introduction of legislation in the Michigan House of Representatives. House Bill 4648 is a bill to amend the Older Michiganians Act of 1981 to further define long-term care as a continuum of care through organization and coordination of: 1) care management, 2) preadmission screening, 3) adult day care, 4) respite care, and 5) in-home services.[75] This bi-partisan bill has drawn immediate support from constituencies such as the American Association of Retired Persons, the Area Agencies on Aging

---

[74] Ibid.

[75] Michigan House of Representatives, House Bill 4648, Lansing, Michigan, May 1987, p. 2.

Association of Michigan, and the state's Commission on Services to the Aging.[76]

This bill recognizes and was written in response to the Care Management demonstration, and requires the Office on Services to the Aging to report on the success of the demonstration project and the feasibility of expanding the program statewide. The legislature is requesting that OSA supply the rationale for a continuum of long-term care based on the general research and cost considerations supplied by the demonstration. It is also an important recognition, in this state, of the role of case management in the long-term care system.

The case management model appears to be gaining recognition in Michigan and elsewhere as a method of implementation for a continuum of care objective for long-term care services. Each demonstration has advanced the knowledge of management of community-based services for the elderly and others who need assistance, but do not need to be institutionalized. Researchers have tested many different forms and methods of collecting data. In addition to the data which these demonstrations have provided, there is an increased awareness to the use of case management as an implementation strategy.

A measure of case management's acceptance as a mechanism for achieving continuum of care will be found in

---

[76] Press release from the office of The Honorable Nate Jonker, Michigan House of Representatives, Lansing, Michigan, May 19, 1987.

the formation of policy, such as Michigan House Bill 4648, and the funding of programs like the Michigan Care Management project. This mechanism has potential to contribute a great deal, not only to the organization of the long-term care system, but also to the quality of life for the elderly in the United States.

Care management's major challenge will be to respond to the growing number of elderly in the population. If caseloads for agencies cannot be expanded beyond sixty to ninety clients, in an elderly population base as large as 22,000 (less than one-half of one percent served by Care Management), this mechanism for achieving a continuum of care with community-based resources will not succeed. The answer would not appear to be financial resources alone, there must also be the cadre of trained social service and health care personnel needed to staff case management positions. These are rather technical staff resources, for which development and training is critical in the remaining years before the boom in the elderly population.

Chapter Eight: Recommendations for The Case Management Model

Long-term care is a part of a larger social system, and is also generally accepted as a part of the health care system, which addresses particular needs of specific population groups. Long-term care has not, to date, benefited from a comprehensive, consistent national policy for identifying need or providing services. Nevertheless, planning for long-term care requires a recognition of specific issues surrounding the population served and resources require. Historically, this planning was limited to creation of institutions to provide care in what is now thought to be a very restrictive setting. As social conscience changed, attitudes toward the use of institutions changed as well.

Currently, among advocates for the elderly, planners, and policy makers, there is a tenet that long-term care services should exist along a continuum. This continuum has as its goal maximizing the independence of the individual through providing the necessary services to maintain the individual in the least restrictive setting. Implementation of the goal requires a mechanism which will match individual's need with services, monitor the results and adjust the services to the changing needs over time. Such a mechanism is case management, which includes: 1) outreach and identification of clients at risk of institutionalization, 2) screening and assessment of need, 3) care planning, 4) service arrangement to implement the plan, and 5) ongoing

monitoring and periodic reassessment. Case management is a complex implementation strategy which has potential benefits, not only to the individual client receiving services, but to the planning process as well. Case management is a practical response to an attempt to bring the fragmented array of services, policies, and programs which comprise the long-term care system, into a continuum of care.

The need for a practical response is evident by the growing portion of the population that is over the age of sixty-five years. By the year 2030 this group will represent twenty percent of the population nationwide, and fifteen percent of Michigan's population. The need is further evidenced by the costs of providing care to this group. A traditional response in providing care has been placement of individuals in institutions, which is costly and burdensome to public programs such as Medicare and Medicaid. These programs have responded to this burden through implementation of prospective payment systems, and other incentives to reduce institutionalization.

Several projects initiated at a local or state level have begun to explore the case management mechanism in delivery of long-term care services. These demonstration projects have supplemented the body of knowledge of service planning and delivery using case management. While results from these demonstrations have not proven conclusively that in-home services are significantly less costly than institutionalization, there were client satisfaction benefits which

would be difficult to measure in terms of cost. Furthermore, the assessment and plan development process in case management provides useful information in identifying the needs of the system, in terms of services required to maximize individuals' independence. One significant result noted was Michigan's Care Management program leading to a recognition of need and funding (potential) of a rural health clinic in Michigan's Upper Peninsula for the elderly by the Kellogg Foundation.

It is the recommendation of this thesis that case management be refined as an implementation method of providing a continuum of long-term care services. It is also recommended that case management be considered as an input to the health planning process, as a source of data for determining both the needs of the population and the status of the service system, and a means by which long-term care can be standardized with respect to definitions of need and services. One way in which this may be done is to expand the assessment process beyond the clients of the Care Management program, and to build a state-wide data base of these assessments. There is little evidence that any methods currently employed in health planning (i.e. budget preparation or survey) provides a better source of planning data, and case management data would be a constant source of information on needs and services within the community. There are implications for planners in transportation and housing as well. Assessment of need also includes data on

existing housing conditions and transportation needs. If the assessment process could be shown to be representative of the aged population of the community, inferences could be drawn for housing and transportation.

There is evidence which suggests that case management has the potential to affect quality of care. This is an area in which planning has an obligation, but has been unable to successfully address thus far. Case managers, as brokers for services and monitors of service delivery, are in the position to evaluate quality of care by applying predetermined standards of evaluation. Unfortunately policy makers have, as of now, missed this opportunity to further influence the quality of care give to the elderly in need of long-term care services.

APPENDICES

FORMS USED IN THE CARE MANAGEMENT PROGRAM

APPENDIX A

PRESCREENING TOOL

Case Management
PRE-SCREENING TOOL GUIDE

I. Description

This is a guide to use in determining how to score each question on the Pre-Screening Tool. A score of 0, 1, 2 or 4 is given as a point value or score to each question. Definitions describing possible responses are presented below to determine a person's present situation or condition with corresponding point values for each. The tool is structured to be used for interviewing potential client's or referral sources.

II. Instructions

- Ask all questions on the pre-screening tool. Check yes or no for each question asked.
- Choose one answer (from the guide) for each question that best describes the client's present condition or situation.
- Record the corresponding point value or score for each response at the end of each question in the Comment and Score section on the right hand column of the page.
- Add comments as necessary to reflect client's situation more definatively for your own use on the pre-screening tool.
- Add the total points or scores for all questions at the end of the pre-screening tool.
- If the total score is 20 points or above, the client is eligible for case management.
- If the total score is below 20 points, the client is not eligible for case management.

III. Question Scoring/Answer Definitions by Client Response
(corresponds to questions on pre-screening tool)

A. Physical Functioning:

1. Do you or does person have an injury or illness that requires someone to help you? (such as a stroke or heart problems)

   - No . . . . . .Score = 0
   - Yes, has this problem, but is not serious or severe. Able to manage adequately . . . . . .Score = 0
   - Yes, has problem but receives assistance as needed. This assistance is expected to continue . . .Score = 0

- Yes, has a problem. Is presently receiving help, but the caregiver is wearing out or stressed. Care giver will continue but could use assistance . . . . . Score = 2

- Yes, has a problem. Receives assistance, but assistance is not sufficient to meet total need. (i.e., it is not frequent enough) . . . . . Score = 2

- Yes, has a problem and is presently not receiving assistance. . . . . .Score = 4

- Yes, has a problem, receives assistance but this assistance will not continue. . . . . .Score = 4

2, 3, 4 (Score 0, 2, 4)

2. Can you wash or bathe yourself?

3. Can you get out of the house to go shopping or see you physician? Determine: a) Is the client homebound?; b) What does the client do for transportation?

4. Can you do housework and prepare your own meals?

- Yes, fully capable or is able to manage adequately. No problem evident. . . . . Score = 0

- No, but receives help as needed and assistance will continue. . . . . Score = 0

- No, is receiving help but caregiver is stressed or assistance is not sufficient to meet total needs. . . . . Score = 2

- No, does not have assistance or has help that will not continue . . . . . .Score = 4

B. Social/Emotional

5. Do you have family or friends living nearby that are in contact with you on a regular basis?

- Yes, has contact on a regular basis . . . . . .Score = 0

- Yes, but relationships or contact is strained . . . . .Score = 2

- Yes, has contact but is limited or too infrequent . . .Score = 2

- Yes, but contact will not continue . . . . . Score = 4

- No. Isolation or loneliness is apparent and problematic . . . . . Score = 4

6. Have you experienced any major changes in your life that you are having difficulty coping with?

   - No. No problem is evident . . . . . Score = 0
   - Yes. A general answer; i.e., "my friends are always dying." . . . . . .Score = 1
   - Yes. A specific event is delineated; i.e., "I just lost my husband (or other significant person) . . . . .Score = 2

7. Disoriented/Impaired Judgment

   Self-Referral - Questions to person on page 1 of Pre-Screening Tool, A, B, and C, scoring is identical to Referral Source below:

   A. What is your birth date?

   B. Please tell me your marital status?

   C. Please tell me your home address.

   Referral Source - Question regarding person being referred. Is person confused or disoriented to time, date, or place?

   - Not confused or disoriented. . . . . Score = 0
   - Some confusion or forgetfulness, but the problem is not severe or serious or assistance is provided and will continue. . . . . Score = 2
   - Person is confused or disoriented which presents a severe problem; i.e., with medications or cooking. . . . . .Score = 4

C. Barriers:

8. Do you have adequate heating in your home?

   - Yes . . . . . .Score = 0
   - Yes, however, a non-specific or non-urgent problem exists (i.e., heating cost is too expensive and the person may not be able to continue paying for it. .Score = 1
   - Yes, adequate heating presently, but the person has to sacrifice on purchase of something else important to pay for it; (i.e., medicine, food). . . . . Score = 2
   - No. . . . . .Score = 2

9. A. Is your home environment safe?
If yes, go to 9-B.
If no, score question go to question 10. . . . . Score = 2

B. If yes, are there any stairs or other obstacles in the house that make it difficult for you to get around?

- No. . . . . .Score = 0
- Yes, but has sufficient assistance which will continue . . . . . Score = 0
- Yes, has help but the assistance is stressed or not sufficient to meet all needs. . . . . .Score = 1
- Yes, and no assistance is present or has help that will not continue. . . . . .Score = 2

10. Are you eating a well-balanced diet? (Probe if you have any doubt about the way the person responds to this question.

- Yes . . . . . .Score = 0
- No, person doesn't eat all meals with regard to good nutritional habits, but does eat one well-balanced meal daily and is not prescribed a special diet . . . . . Score = 1
- No, person consistently demonstrates poor nutritional habits or doesn't follow prescribed special diet (i.e., diabetic, low-salt). . . . . Score = 2

D. Medical

11. Have you been in a hospital in the last year?

- No. . . . . .Score = 0
- One time in the last year . . . . . .Score = 1
- Two or more times in the last year. . . . . .Score = 2

12. Have you been in a nursing home or other institutional facility in the last year? (Institutional facility in this question does not apply to hospitals.)

- No, hasn't been institutionalized within last two years . . . . . .Score = 0
- No, but has been institutionalized between 1-2 years ago. . . . . Score = 1
- Yes, currently or within the last year. . . . . .Score = 2

13. Has anyone discussed other living arrangements for you, such as a nursing home, or foster care home.

- No. . . . . .Score = 0
- Yes, discussed by physician, hospital or significant other as an option with no firm decision. Responses connotes lack of immediacy or urgency. . . . . .Score = 2
- Yes, has definitely been recommended by the physician or significant other. . . . . .Score = 4

14. Are you considering moving to a nursing home?

- No. . . . . .Score = 0
- Yes, considered by person or primary caregiver as an option with no firm decision. Response connotes lack of immediacy or urgency. . . . . Score = 2
- Yes, is seriously considering a move. Response does connote urgency. . . . . .Score = 4

15. Have you had to go to your physician for reasons other than regular check-up appointments within the last six months?

- No and no apparent need. . . . . Score = 0
- Yes. Has seen a physician unexpectedly at least once in the last six months . . . . . .Score = 1
- No. Has not seen a physician within the last three years (i.e., may need to see a physician but refuses to go). . . . . .Score = 1
- Yes, two or more unexpected visits in the last six months. . . . . .Score = 2

16. Do you need help taking your medications?

- No. . . . . .Score = 0
- Yes, but has assistance which will continue . . . . . Score = 0
- Yes, has assistance, but caregiver is wearing out or stressed . . . . . .Score = 1
- Yes, and lacks sufficient assistance or has assistance which will not continue. . . . . .Score = 2

TOTAL SCORE ON PRE-SCREENING FORM: _____

Developed by Tim McIntyre, Region IV Care Management, St. Joseph, Michigan.

APPENDIX B

CLIENT PROFILE

Interview

Thank-you very much. Those are all the questions I have to ask you today. As I explained earlier I will be back again to talk with you in 6 months. I will phone you in 3 months to see how you are doing.

I'd like to tell you about the program that you will receive.

[OPEN UP ENVELOPE] [IF I & R THEN GO TO "A"]
[IF CASE MANAGEMENT THEN GO TO "B"]

A. INFORMATION & REFERRAL:

The program's name is called Information & Referral. Our community has one place where people can call for information about the services that are available for older individuals. You can call this number [POINT OUT NUMBER & CIRCLE IN RED PEN] and someone will help you to find the assistance that you may feel that you need. It is important that you call the Information & Referral program if you want more help than you are receiving now.

Before I leave I also want to give you a list of services that are commonly used by older individuals in our community. If you wish to contact any of these services their telephone numbers are printed on this list. [GIVE A BRIEF EXPLANATION OF EACH SERVICE CATEGORY]

Remember, if you feel that you would like to talk with someone about getting more help for yourself call the Information & Referral service. The number is on this sheet. I have circled it in red. Do you have any questions?

Thank you again for taking the time to talk with me and for answering my questions. I will call you in 3 months and I will be back to talk with you in 6 months. I hope you enjoy the rest of your day.

B. CASE MANAGEMENT:

The program's name is called Case Management. Someone from their office will call you either today or tomorrow to arrange to meet with you. A nurse and/or a social worker will visit you in your home to discuss any help that you feel you need. They will then assist you in receiving services. They want to help you to be comfortable in your own home. Do you have any questions?

Thank you again for taking the time to talk with me and for answering my questions. I will call you in 3 months and I will be back to talk with you in 6 months. I hope you enjoy the rest of your day.

A. CLIENT PROFILE

First I'd like to find out a little about you and your living situation. You may have recently answered a few questions similar to the ones I am going to ask now. But it is important that I ask them again so that we will have the same information on everyone.

A1. Do you have any children?

1= YES

2= NO __

IF YES: A1a. How many children do you have? _____ __ __

(NOTE: REFERS ONLY TO LIVING CHILDREN.)

A2. What was the highest grade level that you completed in school?

1= ELEMENTARY

2= HIGH SCHOOL

3= 2 YEAR COLLEGE (TECHNICAL, COMMUNITY, 2 YRS UNIVERSITY)

4= 4 YEAR UNIVERSITY (OR BEYOND)

5= OTHER (SPECIFY: _____) __

A3. What was your occupation or major area of work?

_____ __ __

SITE/CLIENT ID __ __ - __ __ __

A4. Does anyone else live with you?

1= YES

2= NO __

(IF YES)

A5. Will you please give me the names of all household members, and tell me how they are related to you?

1=	2=	3=	4=	5=	6=	7=	
Spouse	Child	GrChild	Sibling	Parent	Other Rel	Non Rel	
NAMES:			RELATIONSHIP:				
1._____			1 2 3 4 5 6 7				__
2._____			1 2 3 4 5 6 7				__
3._____			1 2 3 4 5 6 7				__
4._____			1 2 3 4 5 6 7				__
5._____			1 2 3 4 5 6 7				__
6._____			1 2 3 4 5 6 7				__
7._____			1 2 3 4 5 6 7				__
8._____			1 2 3 4 5 6 7				__
9._____			1 2 3 4 5 6 7				__
10._____			1 2 3 4 5 6 7				__

SITE/CLIENT ID __ __ - __ __ __

B. HEALTH PROFILE

PART 1 -- PHYSICAL HEALTH

Let's talk about your health now.

B1. How would you rate your overall health at the present time--would you say it was excellent, good, fair, or poor?

1= EXCELLENT

2= GOOD

3= FAIR

4= POOR _____

B2. Is your health now better, about the same, or worse than it was 6 months ago?

1= BETTER

2= ABOUT THE SAME

3= WORSE _____

B3. How much do your health troubles stand in the way of your doing things you want to do--not at all, a little (some) or a great deal? [e.g Recreational or social things]

1= NOT AT ALL

2= A LITTLE

3= A GREAT DEAL _____

B4. During this last month how many days did you stay in bed most or all of the day either because you were too ill to get up or because you just didn't feel like getting up (either at home or in the nursing home)? [MOST OF DAY = MORE THAN HALF OF DAY]

(# DAYS) _____

(NOTE: EXCLUDES HOSPITAL DAYS)

SITE/CLIENT ID _____ - _____

B5. Considering all parts of your life right now. How satisfied would you say you are with your life.

Would you say you are...

1=Very Satisfied
2=Satisfied
3=Dissatisfied
4=Very Dissatisfied _____

Now I'd like to talk about your eating habits.

B6. Could you please tell me what you ate yesterday?

PROBE: It may help to start with what you ate for breakfast.

(NOTE: RECORD FOOD ITEMS NOW--CIRCLE LATER)

BREAKFAST_____

LUNCH_____

SUPPER_____

SNACKS_____

(CIRCLE ALL THAT APPLY)

	1=YES 2=NO
1= DAIRY PRODUCTS, SUCH AS MILK, CHEESE, OR YOGURT	___
2= PROTEIN FOODS SUCH AS MEAT, POULTRY, FISH, EGGS, OR DRIED BEANS	___
3= FRUITS OR VEGETABLES-EITHER RAW, COOKED OR CANNED	___
4= FOODS MADE FROM GRAINS, SUCH AS BREAD, CEREAL, NOODLES OR RICE	___
5= DID NOT EAT YESTERDAY [1=TRUE 2=FALSE]	___
6= DOES NOT EAT AT ALL (IV TUBES) [1=TRUE 2=FALSE]	___

SITE/CLIENT ID __ __ - __ __ __

C. FORMAL SERVICES UTILIZATION

Now please tell me the names of people who regularly come to help you as part of their paid or volunteer work. These could be people who come from an agency or organization or people you hired. [IF NONE, GO TO C4]

REGULARLY = AT LEAST ONCE A MONTH

SPACE (C1-C3) IS PROVIDED FOR 3 FORMAL CAREGIVERS.

C1. _____ — — — —
(NAME #1)

a. What agency or organization was NAME from?

_____ — — — —
(AGENCY/ORGANIZATION)

b. How often does NAME come to help you?

____ — —
(# OF TIMES EACH MONTH)

c. How long does NAME usually stay each visit?

____ — — —
(MINUTES)

d. When did NAME first begin coming to your home?

---------/----- — — — —
(MONTH) (YEAR)

e. Is NAME currently coming to help you?

1= YES

2= NO —

IF NO: When did you stop receiving services from NAME?

_____/_____ — — — —
(MONTH) (YEAR)

SITE/CLIENT ID __ __ - __ __ __

f. Would you say that you were very satisfied, satisfied, or not too satisfied with NAME'S provision of this service?

1= VERY SATISFIED

2= SATISFIED

3= NOT TOO SATISFIED ___

g. How did you arrange for NAME to provide this service?

1= SELF
2= FRIEND/RELATIVE
3= INFORMATION & REFERRAL
4= CASE MANAGEMENT
5= DSS
6= PUBLIC HEALTH
7= DISCHARGE COORDINATOR/PHYSICIAN
8= OTHER (_____) ___

h. How are these services paid for?

1= SELF

2= FRIEND/RELATIVE

3= VOLUNTEER

4= GOVERNMENT

5= INSURANCE

6= SELF & OTHER (SPECIFY _____) ___

i. What does NAME help you with ?
(CIRCLE ALL THAT APPLY) 1=YES 2=NO

1= Skilled nursing and therapies ___
2= Chore services/homemaker (housework, laundry, shopping) ___
3= Meals ___
4= Personal care-unskilled (Bathing, dressing) ___
5= Transportation ___
6= Home upkeep (repairs, lawn care, snow removal) ___
7= Managing money ___
8= Taking medication ___
9= Other (SPECIFY) _____ ___

SITE/CLIENT ID __ __ - __ __ __

FORMAL SERVICES CONT. [IF NO ADDITIONAL SERVICES GO TO C4]

(NAME #2)

C2. _____ (NAME #2) — — — —

a. What agency or organization was NAME from?

_____ (AGENCY/ORGANIZATION) — — — —

b. How often does NAME come to help you?

_____ (# OF TIMES EACH MONTH) — —

c. How long does NAME usually stay each visit?

_____ (MINUTES) — — —

d. When did NAME first begin coming to your home?

---------/-----
(MONTH) (YEAR) — — — —

e. Is NAME currently coming to help you?

1= YES

2= NO —

IF NO: When did you stop receiving services from NAME?

_____/_____ (MONTH) (YEAR) — — — —

f. Would you say that you were very satisfied, satisfied, or not too satisfied with NAME'S provision of this service?

1= VERY SATISFIED

2= SATISFIED

3= NOT TOO SATISFIED —

SITE/CLIENT ID __ __ - __ __ __

g. How did you arrange for NAME to provide this service?

1= SELF

2= FRIEND/RELATIVE

3= INFORMATION & REFERRAL

4= CASE MANAGEMENT

5= DSS

6= PUBLIC HEALTH

7= DISCHARGE PLANNER/PHYSICIAN

8= OTHER (_____) ___

h. How are these services paid for?

1= SELF

2= FRIEND/RELATIVE

3= VOLUNTEER

4= GOVERNMENT

5= INSURANCE

6= SELF & OTHER ___

i. What does NAME help you with ?
(CIRCLE ALL THAT APPLY) 1=YES 2=NO

1= Skilled nursing and therapies ___
2= Chore services/homemaker (housework, laundry, shopping) ___
3= Meals ___
4= Personal care-unskilled (Bathing, dressing) ___
5= Transportation ___
6= Home upkeep (repairs, lawn care, snow removal) ___
7= Managing money ___
8= Taking medication ___
9= Other (SPECIFY) _____ ___

SITE/CLIENT ID __ __ - __ __ __

FORMAL SERVICES cont. [IF NO ADDITIONAL FORMAL SERVICES GO TO C4]
(NAME #3)

C3. _____ — — — —
(NAME #3)

a. What agency or organization was NAME from?

_____ — — — —
(AGENCY/ORGANIZATION)

b. How often does NAME come to help you?

_____ — — —
(# OF TIMES EACH MONTH)

c. How long does NAME usually stay each visit?

_____ — — —
(MINUTES)

d. When did NAME first begin coming to your home?

---------/-----
(MONTH) (YEAR) — — — —

e. Is NAME currently coming to help you?

1= YES

2= NO —

IF NO: When did you stop receiving services from NAME?

_____/_____ — — — —
(MONTH) (YEAR)

f. Would you say that you were very satisfied, satisfied, or not too satisfied with NAME'S provision of this service?

1= VERY SATISFIED

2= SATISFIED

3= NOT TOO SATISFIED —

SITE/CLIENT ID __ __ - __ __ __

g. How did you arrange for NAME to provide this service?

1= SELF

2= FRIEND/RELATIVE

3= INFORMATION & REFERRAL

4= CASE MANAGEMENT

5= DSS

6= PUBLIC HEALTH

7= DISCHARGE PLANNER/PHYSICIAN

8= OTHER (_____) __

h. How are these services paid for?

1= SELF

2= FRIEND/RELATIVE

3= VOLUNTEER

4= GOVERNMENT

5= INSURANCE

6= SELF & OTHER (SPECIFY _____) __

i. What does NAME help you with ?
(CIRCLE ALL THAT APPLY) 1=YES 2=NO

1= Skilled nursing and therapies __
2= Chore services/homemaker (housework, laundry, shopping) __
3= Meals __
4= Personal care-unskilled (Bathing, dressing) __
5= Transportation __
6= Home upkeep (repairs, lawn care, snow removal) __
7= Managing money __
8= Taking medication __
9= Other (SPECIFY) _____ __

C4. Do you have any other people or organizations that come into your home at least once a month as part of their paid or volunteer work?

TOTAL NUMBER OF FORMAL SERVICES __ __

SITE/CLIENT ID __ __ - __ __ __

D. INFORMAL SERVICES UTILIZATION

Next, please tell me the names of friends, neighbors, or family members (who do not live with you) who regularly come to help you. Please do not include people who help you as part of their paid or volunteer work.

REGULARLY = AT LEAST ONCE A MONTH. [IF NONE GO TO D4]

SPACE (D1-D3) IS PROVIDED FOR 3 INFORMAL CAREGIVERS.

[MUST PROVIDE PRACTICAL ASSISTANCE]

D1. _____ — — — —
(NAME #1)

a. How is NAME related to you?

_____ — —
(RELATIONSHIP)

b. How often does NAME come to help you?

_____ — —
(# OF TIMES EACH MONTH)

c. How long does NAME usually stay each visit?

_____ — — —
(MINUTES)

d. When did NAME first begin coming to your home to do these services?

---------/-----
(MONTH) (YEAR) — — — —

e. Is NAME currently coming to help you?

1= YES

2= NO —

IF NO: When did you stop receiving services from NAME?

_____/_____ — — — —
(MONTH) (YEAR)

SITE/CLIENT ID __ __ - __ __ __

f. Would you say that you were very satisfied, satisfied, or not too satisfied with NAME'S help?

1= VERY SATISFIED

2= SATISFIED

3= NOT TOO SATISFIED ___

g. How did you arrange for NAME to help you?

1= SELF

2= FRIEND/RELATIVE

3= INFORMATION & REFERRAL

4= CASE MANAGEMENT

5= DSS

6= PUBLIC HEALTH

7= DISCHARGE PLANNER/PHYSICIAN

8= OTHER (_____) ___

h. What does NAME help you with ?
(CIRCLE ALL THAT APPLY) 1=YES 2=NO

1= Skilled nursing and therapies ___
2= Chore services/homemaker (housework, laundry, shopping) ___
3= Meals ___
4= Personal care-unskilled (Bathing, dressing) ___
5= Transportation ___
6= Home upkeep (repairs, lawn care, snow removal) ___
7= Managing money ___
8= Taking medication ___
9= Other (SPECIFY) _____ ___

SITE/CLIENT ID __ __ - __ __ __

INFORMAL SERVICES UTILIZATION cont. [IF NONE GO TO D4]

D2. _____ — — — —
(NAME #2)

a. How is NAME related to you?

_____ — —
(RELATIONSHIP)

b. How often does NAME come to help you?

_____ — —
(# OF TIMES EACH MONTH)

c. How long does NAME usually stay each visit?

_____ — — —
(MINUTES)

d. When did NAME first begin coming to your home to do these services?

---------/-----
(MONTH) (YEAR) — — — —

e. Is NAME currently coming to help you?

1= YES

2= NO —

IF NO: When did you stop receiving services from NAME?

_____/_____ — — — —
(MONTH) (YEAR)

f. Would you say that you were very satisfied, satisfied, or not too satisfied with NAME'S help?

1= VERY SATISFIED

2= SATISFIED

3= NOT TOO SATISFIED —

g. How did you arrange for NAME to help you?

1= SELF

2= FRIEND/RELATIVE

3= INFORMATION & REFERRAL

4= CASE MANAGEMENT

5= DSS

6= PUBLIC HEALTH

7= DISCHARGE PLANNER/PHYSICIAN

8= OTHER (_____) __

h. What does NAME help you with ?
(CIRCLE ALL THAT APPLY) 1=YES 2=NO

1= Skilled nursing and therapies __
2= Chore services/homemaker (housework, laundry, shopping) __
3= Meals __
4= Personal care-unskilled (Bathing, dressing) __
5= Transportation __
6= Home upkeep (repairs, lawn care, snow removal) __
7= Managing money __
8= Taking medication __
9= Other (SPECIFY) _____ __

SITE/CLIENT ID __ __ - __ __ __

INFORMAL SERVICES UTILIZATION cont. [IF NONE GO TO D4]

D3. _____ (NAME #3) — — — —

a. How is NAME related to you?

_____ (RELATIONSHIP) — —

b. How often does NAME come to help you?

_____ (# OF TIMES EACH MONTH) — —

c. How long does NAME usually stay each visit?

_____ (MINUTES) — — —

d. When did NAME first begin coming to your home to do these services?

---------/----- (MONTH) (YEAR) — — — —

e. Is NAME currently coming to help you?

1= YES

2= NO —

IF NO: When did you stop receiving services from NAME?

_____/_____ (MONTH) (YEAR) — — — —

f. Would you say that you were very satisfied, satisfied, or not too satisfied with NAME'S help?

1= VERY SATISFIED

2= SATISFIED

3= NOT TOO SATISFIED —

SITE/CLIENT ID __ __ - __ __ __

g. How did you arrange for NAME to help you?

1= SELF

2= FRIEND/RELATIVE

3= INFORMATION & REFERRAL

4= CASE MANAGEMENT

5= DSS

6= PUBLIC HEALTH

7= DISCHARGE PLANNER/PHYSICIAN

8= OTHER (_____) __

h. What does NAME help you with ?
(CIRCLE ALL THAT APPLY) 1=YES 2=NO

1= Skilled nursing and therapies __
2= Chore services/homemaker (housework, laundry, shopping) __
3= Meals __
4= Personal care-unskilled (Bathing, dressing) __
5= Transportation __
6= Home upkeep (repairs, lawn care, snow removal) __
7= Managing money __
8= Taking medication __
9= Other (SPECIFY) _____ __

D4. Do you have any other family, friends or neighbours that regularly come into your home to help you. _____

TOTAL NUMBER INFORMAL CAREGIVERS __ __

SITE/CLIENT ID __ __ - __ __ __

E. SOCIAL SUPPORT

SOCIAL SUPPORT INTERVIEW QUESTIONS (CODE ON SUPPORT CODE SHEET)

[USE THESE QUESTIONS ALONG WITH THE SOCIAL SUPPORT CODING SHEET. IF THE "NAMED PERSON" IS ALREADY ON THE SHEET CIRCLE 1=YES IF THEY ARE NOT ON THE SHEET ADD THEIR NAME IN THE NEXT AVAILABLE SPACE AND ALSO CIRCLE 1=YES. IF A NAME THAT IS ALREADY ON THE SHEET IS NOT MENTIONED THEN CIRCLE 2=NO. YOU CAN CIRCLE THE "NO" ANSWERS AFTER THE INTERVIEW IS COMPLETED]

* * *

Now I'm going to ask you some questions about people who are part of your life who provide you with help or social support. As I ask each question, I want you to name only those people who come to mind quickly.

E1. In an average week who do you enjoy chatting with?

E2. Who can you rely on for advice about resources? (e.g. advice about services available in the community?)

E3. Who can you count on to listen to you when you want to talk about something personal? (e.g. someone who will listen to your feelings.)

E4. Who cares about you?

E5. Who makes your life difficult; such as someone who expects too much from you or makes too many demands on you, someone who you wish would leave you alone or someone you would like to avoid?

SITE/CLIENT ID __ __ - __ __ __

* ASK THE FOLLOWING QUESTIONS (E6-E9) FOR EACH PERSON THAT HAS BEEN MENTIONED AND WHO'S NAME YOU MARKED ON THE SUPPORT CODING SHEET. THIS INCLUDES ALL NAMES THAT HAVE BEEN MARKED ON THE CODING SHEET. ALL NAMES THAT WERE MENTIONED IN QUESTION A5 AND IN SECTIONS C AND D (SERVICES) SHOULD BE CODED HERE.

ASK ITEMS E6-E9 ACROSS SUPPORT SHEET FOR EACH NAME BEFORE MOVING TO NAME ON NEXT LINE

E6. What is the SEX of the caregiver? (ASK ONLY IF GENDER IS NOT CLEAR)

1=MALE 2= Female

E7. What is the AGE of the caregiver? (If respondent does not know ask them to guess)

E8. What is your main relationship with this person? (Enter the appropriate code number on the code sheet.)

01 = ROMANTIC
02 = SPOUSE
03 = RELATIVE
04 = FRIEND
05 = NEIGHBOUR
06 = PROFESSIONAL (doctor, nurse, case manager)
07 = FORMAL VOLUNTEER
08 = PAID HELP (homemaker, personal care)
09 = PAID COMMUNITY SERVICE (taxi, bus, grocery clerk)
10 = OTHER (SPECIFY)

E15. Think about how important your relationship with (NAME) is to you. Relative to the other names that you have given me would you say the relationship was important or unimportant?

IF IMPORTANT - READ 5,6,7

IF UNIMPORTANT - READ 1,2,3

Would you say it was...

1 = Extremely Unimportant
2 = Very unimportant
3 = Unimportant
4 = EQUALLY IMPORTANT AND UNIMPORTANT
5 = Important
6 = Very Important
7 = Extremely Important

SITE/CLIENT ID __ __ - __ __ __

F.AUTONOMY

F1. Please complete this sentence. "The decision about the type of help I receive is totally my decision, is shared equally with another person,or is totally another person's decision."

1= TOTALLY MY DECISION

2= SHARED EQUALLY

3= TOTALLY ANOTHER PERSON'S DECISION __

F2. "The decision about the doctors I see is totally my decision, is shared equally with another person,or is totally another person's decision."

1= TOTALLY MY DECISION

2= SHARED EQUALLY

3= TOTALLY ANOTHER PERSON'S DECISION __

F3. "The decision about how I spend time during the day is totally my decision, is shared equally with another person, or is totally another person's decision."

1= TOTALLY MY DECISION

2= SHARED EQUALLY

3= TOTALLY ANOTHER PERSON'S DECISION __

F4. "The decision about who visits me is totally my decision, is shared equally with another person, or is totally another person's decision."

1= TOTALLY MY DECISION

2= SHARED EQUALLY

3= TOTALLY ANOTHER PERSON'S DECISION __

SITE/CLIENT ID __ __ - __ __ __

AUTONOMY cont.

F5. Overall, how much control do you have over things that happen to you in your life--would you say that you have a great deal of control, a fair amount of control, little control, or no control?

1= GREAT DEAL

2= FAIR AMOUNT

3= LITTLE

4= NONE ___

SITE/CLIENT ID __ __ - __ __ __

G. FINANCIAL RESOURCES

The next questions are about your insurance.

G1. Are you covered by Medicare

1= YES [RED WHITE & BLUE CARD]
2= NO ___

PROBE: Is something deducted from your Social Security check?

G2. Are you covered by Medicaid?

1= YES [BLUE CARD]
2= NO ___

G3. What about the following kinds of medical or health plans? Are you covered by any of these?

	YES	NO	
a. Private insurance which supplements Medicare, and covers hospitalization?	1	2	___
b. Private insurance which supplements Medicare and covers doctors' bills?	1	2	___
c. Membership in an HMO (Health Maintenance Organization)	1	2	___
d. Veterans medical insurance?	1	2	___
e. Any other medical or health insurance?	1	2	___

SPECIFY: _____

SITE/CLIENT ID __ __ - __ __ __

G4. What are your sources of income?

	YES	NO	
a. WAGES (OWN OR SPOUSE)	1	2	___
b. CHILDREN OR RELATIVES	1	2	___
c. SOCIAL SECURITY	1	2	___
d. ANNUITIES, SAVINGS, ETC.	1	2	___
e. OLD AGE ASSISTANCE [GOLD CHECK]	1	2	___
f. PENSIONS	1	2	___

[PROBE: Do you have any savings?]

G5. Which of these [ABOVE] is your major source of income?

[MAJOR = PROVIDES MOST DOLLARS PER MONTH]

1= WAGES (OWN OR SPOUSE)

2= CHILDREN OR RELATIVES

3= SOCIAL SECURITY

4= ANNUITIES, SAVINGS, ETC.

5= OLD AGE ASSISTANCE

6= PENSIONS ___

SITE/CLIENT ID __ __ - __ __ __

G6. How much income do you (and your husband/wife) have a year?

(NOTE: SHOW CARD)

a. 01=0-$499

b. 02=$500-$999

c. 03=$1,000-$1,999

d. 04=$2,000-$2,999

e. 05=$3,000-$3,999

f. 06=$4,000-$4,999

g. 07=$5,000-$6,999

h. 08=$7,000-$9,999

i. 09=$10,000-$14,999

j. 10=$15,000-$19,999

k. 11=$20,000-$29,999

l. 12=$30,000-$39,999

m. 13=$40,000 OR MORE ___

G6a How many people altogether live on this income (that is, it provides at least half of their income)?

_____ ___

G7. How would you describe the adequacy of your income? Would you say that is is very adequate, somewhat adequate, or not adequate?

1= VERY ADEQUATE

2= ADEQUATE

3= NOT ADEQUATE _

SITE/CLIENT ID __ __ - __ __ __

H. OBSERVATIONS

H1. CLIENT'S RACE ?

1= NEGRO

2= CAUCASIAN

3= HISPANIC

4= ORIENTAL

5= INDIAN

6= OTHER (SPECIFY:_____) __

H2. TYPE OF COMMUNITY IN WHICH CLIENT LIVES:

LARGE CITY (250,000 OR MORE) 1

SUBURB OF LARGE CITY 2

MEDIUM-SIZED CITY (50,000-250,000) . . 3

SUBURB OF MEDIUM CITY 4

SMALL CITY (5,000-50,000) 5

SMALL TOWN (LESS THAN 5000) 6

RURAL 7

OTHER (SPECIFY) _____ 8 __

H3. CLIENT'S CURRENT LIVING ARRANGEMENT:

PRIVATE HOME, ROOM OR APARTMENT 1

ADULT FOSTER CARE/BOARDING HOUSE 2

(NAME: _____)

SENIOR CITIZEN APARTMENTS 3

(NAME: _____)

NURSING HOME 4

(NAME: _____)

OTHER (SPECIFY : _____).....5

SITE/CLIENT ID __ __ - __ __ __

OBSERVATIONS cont.

H4. DURING THE ASSESSMENT, DID THE CLIENT'S BEHAVIOR STRIKE YOU AS:

	YES	NO	CANNOT DETERMINE	
a. MENTALLY ALERT AND STIMULATING	1	2	3	__
b. PLEASANT AND COOPERATIVE . .	1	2	3	__
c. DEPRESSED AND/OR TEARFUL . .	1	2	3	__
d. FEARFUL, ANXIOUS, OR EXTREMELY TENSE . . .	1	2	3	__
e. FULL OF UNREALISTIC COMPLAINTS	1	2	3	__
f. SUSPICIOUS (MORE THAN USUAL)	1	2	3	__
g. BIZARRE OR INAPPROPRIATE (E.G., DISRUPTIVE, ABUSIVE, WANDERING)	1	2	3	__
h. WITHDRAWN OR LETHARGIC . . .	1	2	3	__
i. AGITATED, QUICK, LOUD, AND EMOTIONALLY OVERRESPONSIVE. .	1	2	3	__

H5. WHICH OF THE FOLLOWING BEST DESCRIBES THE CLIENT'S SPEECH:

NO IMPAIRMENT. 1

PARTIALLY IMPAIRED (CAN USUALLY BE UNDERSTOOD BUT HAS DIFFICULTY WITH SOME WORDS) 2

SEVERELY IMPAIRED (CAN BE UNDERSTOOD ONLY WITH DIFFICULTY AND CANNOT CARRY ON A NORMAL CONVERSATION). . . . 3

COMPLETELY IMPAIRED (SPEECH IS UNINTELLIGIBLE OR CANNOT SPEAK) . . . . . 4 __

SITE/CLIENT ID __ __ - __ __ __

OBSERVATIONS cont.

H6. THINKING ABOUT THE CLIENT'S UNDERSTANDING OF THE QUESTIONS, MENTAL FUNCTIONING AND ABILITY TO COMMUNICATE, WOULD YOU SAY THE RESPONSES TO THE QUESTIONS ASKED OF HIM/HER WERE:

COMPLETELY RELIABLE 1

RELIABLE ON MOST ITEMS. 2

RELIABLE ON SOME ITEMS. 3

COMPLETELY UNRELIABLE . . . . . 4 __

H7. BASED ON THE INFORMATION COLLECTED DURING THE INTERVIEW DO YOU BELIEVE THAT THE CLIENT HAS SPECIFIC UNMET NEEDS ?

1= YES

2= NO __

(IF YES)

H8. INDICATE THE AREAS IN WHICH THE CLIENT HAS UNMET NEEDS.

1=YES 2=NO

1= SKILLED NURSING & THERAPIES __
2= CHORE SERVICES/HOMEMAKER (HOUSEWORK, LAUNDRY, SHOPPING) __
3= MEALS __
4= PERSONAL CARE-UNSKILLED (BATHING, DRESSING) __
5= TRANSPORTATION __
6= HOME UPKEEP (REPAIRS, LAWN CARE, SNOW REMOVAL) __
7= MANAGING MONEY __
8= TAKING MEDICATION __
9= OTHER (SPECIFY) __

H9. DID THE CLIENT INDICATE THAT THEY WOULD BE LOSING A PARTICULAR CAREGIVER'S ASSISTANCE WITHIN THE NEXT MONTH?

1= YES

2= NO __

(IF YES)

H10. WHICH CAREGIVER'S WILL BE REMOVING THEIR ASSISTANCE?

NAME _____ __ __ __ __

NAME _____ __ __ __ __

SITE/CLIENT ID __ __ - __ __ __

APPENDIX C

CARE MANAGEMENT MONTHLY REPORTS

CARE MANAGEMENT MONTHLY REPORTS

October 1, 1986 - September 30, 1987

PROJECT: _____ REPORT MONTH _____ DATE SUBMITTED_____

	YTD	MONTH
I. Total Referrals to CM	_____	_____
II. Total Prescreened		
A. Eligible for CM	_____	_____
B. Not Eligible	_____	_____

III. Eligible Client Profile

A. Referral Source of Prescreened CM Clients

	YTD	MONTH
1. Self	_____	_____
2. Family/Friend	_____	_____
3. Hospital	_____	_____
4. Physician	_____	_____
5. Nursing Home	_____	_____
6. Home Health Care	_____	_____
7. Social Services	_____	_____
8. Public Health	_____	_____
9. Other(list)		
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. County of Residence of Prescreened CM Clients

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

C. Total Clients Assessed

1. Male	_____	_____
2. Female	_____	_____

D. Race of Assessed Clients

1. Caucasian	_____	_____
2. Black	_____	_____
3. Asian	_____	_____
4. American Indian	_____	_____
5. Hispanic		
6. Other (List)	_____	_____
_____	_____	_____
_____	_____	_____

E. Marital Status

1. Married		
2. Widowed	_____	_____
3. Divorced	_____	_____
4. Seperated	_____	_____
5. Never Married (single)	_____	_____
6. Unknown	_____	_____

F. Living Status of Assessed Clients

	YTD	MONTH
1. Alone	_____	_____
2. W/Family	_____	_____
3. W/Friends	_____	_____
4. Group Home	_____	_____
5. Spouse Only	_____	_____
6. Other(list for month)	_____	_____
_____		
_____		
_____		

G. Age

1. 60-64	_____	_____
2. 65-69	_____	_____
3. 70-74	_____	_____
4. 75-79	_____	_____
5. 80-84	_____	_____
6. 85-89	_____	_____
7. 90-94	_____	_____
8. 95+	_____	_____

H. Where Assessed

1. Home	_____	_____
2. Hosp.	_____	_____
3. NH/Int	_____	_____
4. Other	_____	_____
_____		
_____		
_____		

I. # of N.H. Residents Returned to Community Through CM Intervention·

	_____	_____

	YTD	MONTH
IV. Clients Assessed/No Further CM Services	_____	_____

V. Case Status as of September 30, 1986 (Carry Over Clients)

Active _____ Inactive _____

VI. YTD Cummulative Case Status

Active		Inactive		Closed	
		1. Maintenance	_____	1. Perm. Inst.	_____
		2. Temp. Inst.	_____	2. Refused CM	_____
		3. Refd. Ser.	_____	3. Death	_____
				4. Maint/Rehab	_____
				5. Moved	_____
				6. Other	_____

GAPS-IN-SERVICES REPORT

October 1, 1986 - September 30, 1987

PROJECT:_____ REPORT MONTH:_____ DATE SUBMITTED:_____

	Not Available	Not Affordable	Waiting List	Service Frequency Not Adequate
Home Health Services				
Skilled Nursing	___	___	___	___
Occupational Therapy	___	___	___	___
Physical Therapy	___	___	___	___
Speech Therapy	___	___	___	___
Home Health Aide	___	___	___	___
Other	___	___	___	___
Medical Services				
Geriatric Assessment	___	___	___	___
Medication Review	___	___	___	___
Prescription	___	___	___	___
Physician Services	___	___	___	___
Vision Care	___	___	___	___
Hearing Care	___	___	___	___
Dental Care	___	___	___	___
Other	___	___	___	___
In-Home Services				
Chore	___	___	___	___
Personal Care	___	___	___	___
Homemaker	___	___	___	___
Home Delivered meals	___	___	___	___
In-Home Respite	___	___	___	___
Telephone Reassurance	___	___	___	___
Home repair	___	___	___	___
Lifeline	___	___	___	___
24 Hour Care	___	___	___	___
Other	___	___	___	___
Community Services				
Adult Day Care	___	___	___	___
Legal Services	___	___	___	___
Transportation	___	___	___	___
Hospice	___	___	___	___
Escort	___	___	___	___
Senior Companion	___	___	___	___
Financial Assistance	___	___	___	___
Congregate Meals	___	___	___	___
Support Groups	___	___	___	___
Other	___	___	___	___

	Not Available	Not Affordable	Waiting List	Service Frequency Not Adequate
Equipment/Supplies				
Durable Medical	___	___	___	___
Barrier Free Mod	___	___	___	___
Medical Supplies	___	___	___	___
Other	___	___	___	___
Mental Health Services				
In-Home Counseling	___	___	___	___
Psychiatric Assess.	___	___	___	___
In-Patient P.A.	___	___	___	___
Out-Patient P.A.	___	___	___	___
Substance Abuse	___	___	___	___
Other	___	___	___	___
Institutional Care				
Skilled Nursing	___	___	___	___
Adult Foster Care	___	___	___	___
Basic/Int. N.H.	___	___	___	___
Home for Aged	___	___	___	___
Acute Care Hospital	___	___	___	___
Other	___	___	___	___

BIBLIOGRAPHY

American Health Planning Association Publication, A Guide for Planning Long Term Care Health Services for the Elderly, Washington, D.C.:AHPA, 1983.

Baker, Mary, Care Management Coordinator, Chippewa, Luce and Mackinac Human Resource Authority, Inc., Sault Ste. Marie, Michigan, Telephone interview, July 13, 1987.

Berki, S.E., "Health Care Policy: Lessons From the Past and Issues of the Future," Annals, AAPSS, 468, (July 1983).

Brody, Stanley J., Planning for the Long Term Support/Care System: The Array of Services to be Considered, a monograph prepared for Region III Center for Health Planning, (Philadelphia, Pennsylvania, June 1979).

Buchwald-Lawton, Edith, Activities of Daily Living for Physical Rehabilitation, New York, New York, McGraw-Hill, 1952.

Eggert, Gerald M., "The ACCESS Process: Assuring Quality in Long Term Care," Coordinated Service Delivery Systems for the Elderly, New York, Haworth Press, 1980.

Eggert, G.M., et.al. "Gaining Control of the Long Term Care System: First Returns from the ACCESS Experiment," Gerontologist, 20, (1980).

Fisher, Charles R., "Differences by Age Groups in Health Care Spending," Health Care Financing Review, 1:4, 1980.

Gorwitz, Kurt, "Zero Population Growth, Implications For Michigan", Michigan Medicine, May 1972.

Graves, Pam, Michigan Office on Services to the Aging, Lansing, Michigan, Interview, June 30, 1987.

Grimaldi, Paul, and Sullivan, Toni, Broadening Federal Coverage of Non-Institutional Long Term Care, Washington, D.C.:American Health Care Association, 1981.

Hobart, Donna, Care Management Director, Tri-County Office on Aging, Lansing Michigan, Interview, July 8, 1987.

Katz, Sidney, "Studies of Illness in the Aged," JAMA, 185:12, September 21, 1963.

Kimmey, James, Health Planning in the United States, Institute for Health Planning, 1982.

Michigan Department of Management and Budget, Office of Health and Medical Affairs, Report of the Task Force on Long Term Care to the Statewide Health Coordinating Council, by John Herrick, Chairman, Lansing, Michigan:OHMA, July 1987.

Michigan Department of Social Services, Data Reporting Section, Medical Assistance: Fiscal Year 1980, Lansing, Michigan, 1980.

Michigan House of Representatives, House Bill 4648, Lansing, Michigan, May 1987.

Michigan House of Representatives, Press release, the office of The Honorable Nate Jonker, Lansing, Michigan, May 1987.

Michigan Office of Services to the Aging, The Aging in Michigan: A Population Profile of the Elderly, by Ching-li Wand and David Youngs, Lansing, Michigan, 1984.

Michigan Office of Services to the Aging, Draft Care Management Standards, Lansing, Michigan, 1987.

Michigan Office on Services to the Aging, Executive Summary, Research Report on Care Management, Lansing, Michigan, 1986.

National Association of Area Agencies on Aging, Statement on Community Based Long-term Care, Washington, D.C., 1983.

Phillips, Barbara, Issues in Developing the Client Assessment Instrument for the National Long-term Care Demonstration Channeling Evaluation, Mathematica Policy Research, Inc.:Princeton, New Jersey, 1981.

Tri-County Office on Aging, Care Management Evaluation: Agency's Report, Lansing, Michigan, May 1987.

Tri-County Office on Aging, Care Management Evaluation: Client Survey, Lansing, Michigan, June 1987.

U.S. Congress, Senate, Special Committee on Aging, Long-term Care in Western Europe and Canada: Implications for the United States, S. Rept. 98-211, 98th Cong., 2d sess., 1984.

U.S. Department of Health and Human Services, Proceedings, Issues in Planning for Long-term Care, September 15-16, 1983, Washington, D.C.

U.S. Department of Health and Human Services, Health Resources and Services Administration, State Initiatives in Long-Term Care, Washington, D.C., August 1984.

U.S. Department of Health and Human Services, National Institute of Health, Technology Assessment Conference, Evaluating the Elderly Patient: A Case for Assessment Technology, June 29-30, 1983, Bethesda, Maryland.

U.S. Department of Health and Human Services, National Center for Health Statistics, Long-Term Health Care: Minimum Data Set, Washington, D.C., 1980.

U.S. Department of Health and Human Services, Administration on Aging, Statistical Reports on Older Americans, Some Prospects for the Future Elderly Population, Washington, D.C., January 1978.

U.S. Department of Health and Human Services, The Evaluation of the National Long-term Care Demonstration: Final Report, Mathematica Policy Research, Inc.: Princeton, New Jersey 1986.

U.S. Department of Health and Human Services, The Evaluation of the National Long-term Care Demonstration: The Planning and Operational Experience of Channeling Projects, Mathematica Policy Research, Inc.: Princeton, New Jersey 1986.

Vogel Ronald J., and Palmer, Hans C., ed., Long-term Care: Perspectives from Research and Demonstrations, (Aspen Systems Corp.: Rockville, Maryland, 1985.

Waldo, Daniel W., and Lazenby, Helen, "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984," Health Care Financing Review, 6:1, Fall 1984.

Wasser, Edna: Creative Approaches in Casework with the Aging, New York: Family Service Association of America, 1966.