Case Management in Family Practice: Assuring Cost-Effective Care for High-Risk Patients

Case management, the latest buzzword in managed care, is a process that has been with us for a long time. The Commission for Case Manager Certification, the leading agency for credentialing case managers, defines case management as "a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes."[1] As such, there are strong parallels between the interests and skills of case managers and those of family physicians. Both disciplines are person-focused. Both address the needs of the individual across a variety of care settings. Both see their role as advocates, facilitators, problem solvers, and educators.[2] Both are trained in and comfortable working in multidisciplinary settings. Both are accustomed to environments where resources to maximize care are limited or absent.

This is not to say that the skills of each discipline are the same or that family physicians can effectively serve as case managers by themselves. A case manager might be involved in any or all of the following activities for a given patient: facilitating communications and coordination in medical matters, establishing and negotiating the patient's health care benefits within their health plan, negotiating directly with hospitals and physicians for less costly rates to maximize the patient's financial resources, and recommending medically appropriate and less costly alternatives to care. Note that case management does not involve direct patient care. It is the close oversight and coordination of care, frequently performed by telephone, that is the defining attribute of case management. In their interactions, family physicians and case managers can quickly recognize the affinity of interests each has on behalf of their patients.

So why is there increasing interest by policy makers, health planners, and managed care executives in case management? For some time it has been apparent that most health care costs are generated by a relatively small percentage of patients who either are critically injured, suffer from a chronic disease, or are otherwise at particular high risk. As managed care has permeated the fabric of health care, traditional cost controls used in the industry—utilization review (prospective, concurrent, or retrospective), physician contracts transferring financial risk from payer to physician at increasingly lower rates (capitation), and even the restructuring of medical practices utilizing physician extenders, hospitalists, and so on—have had very limited success in containing the critical determinants of high health care costs: catastrophic care and patients who have high-risk medical conditions and behaviors.

Health care environments that are financially at risk for the care delivered (which today encompasses most or all components of our health care system) have turned to case management in the hopes of reducing costs and improving care for the few who are the real drivers of greatest utilization. The ongoing tracking of costs and savings is an integral activity of case managers. Some would say that case management by definition is ineffective unless it can show some cost savings.[3]

Case identification or selection is critical for case management. High-risk, high-cost cases can be recognized without much difficulty in most health care systems. Catastrophic cases, patients with long hospital stays or repeated emergency department visits, and health care costs exceeding a predesignated amount per individual can trigger case identification. These cases might include patients with head and spinal cord injuries, premature infants, patients with cancer, acquired immunodeficiency syndrome, stroke, transplants, and so on. A second tier of patients with high-risk,

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high-cost chronic illnesses, including diabetes mellitus, congestive heart failure, chronic obstructive pulmonary disease, renal failure, mental illness, and substance abuse, has recently been the focus of intensive case management.

In this issue of the *JABFP*, Friedhoff[4] addresses this latter category of patients. These patients received uncompensated or charity care in a family practice residency program. Interestingly, Friedhoff used an informal, ill-defined criteria set for case selection (eg, frequent hospital admission, one or more chronic diseases, psychosocial risk). While these criteria might be adequate for the small sample and the short time frame of this pilot program, they would not be sufficient for a more expansive and comprehensive case management program.

A formal needs assessment typically follows case selection. Such an assessment includes a review of the patient's condition, needs, coverage benefits, and resources (personal and family) available to address care needs. Recommendations are then generated in a care plan that best addresses these needs. Once approval is granted from the payer to implement the recommendations, the case manager's responsibility extends to assuring that appropriate, cost-effective services are put in place and monitored with time. The case manager also periodically evaluates the effectiveness of these interventions.

Friedhoff used a team that did not add resources and that appears somewhat top heavy in medical directors. By comparison, as a medical director in a health plan of some 1.2 million members, I alone support and consult with a staff of 11 case managers, most of whom are nurses or social workers by training. And this responsibility is not my only job. Friedhoff provided no details regarding the needs assessment performed or the care plan developed for each of the 19 patients. I hope that such plans were formalized and used during the weekly case management conferences. As noted, the basic interventions did not involve direct care but rather coordination of care.

Friedhoff's program cannot be delivered without additional expense if the population of high-risk patients increases. In our own health plan, case managers are not expected to carry caseloads greater than 50 clients at a time. Admittedly, this staffing ratio might be much higher than is typically recommended. Interventions for appropriate patients selected on the basis of high cost or high utilization can yield impressive cost savings while improving the quality of care for these patients. In this regard, it is important to note that charges were used to document savings in this study rather than true costs, as are typically reported in most literature documenting the cost-savings of care management programs.

While reduced inpatient days were attributed to intensive outpatient management, case managers in health plans typically evaluate and document cost savings of care provided in alternative settings (ie, home-based intravenous therapy versus intravenous therapy in skilled nursing facilities). The charges directly related to case management approached 16 percent of the total charges for the sample of patients. One could have asked for a better accounting of these costs measured against the savings. Nevertheless, these results parallel the experience in larger health care systems, where the savings attributed to case management far exceed program costs. Finally, one can fault the measurement of cost-benefit that somehow fails to incorporate functional status changes and patient satisfaction—measures of changes in quality of care. In my limited reading of the case management literature, tracking these measures is not typically performed. One suspects that this omission will be addressed as the discipline matures.

The relevance of case management in nonacademic, non-staff-model primary care settings within a health maintenance organization is appropriate to question. After all, case management currently occurs at many levels in most health care delivery systems. The need to implement actual case management services within one's own primary care practice will depend on the size of the practice, the financial resources available to support the program, and the magnitude of financial risk incurred by the practice in managing care.

Regardless of how these services are acquired, family physicians should feel comfortable and knowledgeable in working with case managers to benefit the care of their high-risk patients. We and our patients will benefit from this valuable alliance.

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