

Proactive Case Management: Social Work Active Engagement Revisited

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Abstract

Case management is defined as a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services. While the acknowledgment of insuring client-centered care with a focus on ‘client knows their needs and wants,’ the social worker should not abdicate their role in keeping a client in care or even partial care. Using the Proactive Case Management, the social worker goes beyond the silo of services provided by their agency to re-engage, educate, network, advocate, and broker to facilitate the linkages for the individual. Proactive Case Management requires social workers to understand defense mechanisms, transference and counter transference issues, anticipate issues, to stratify risks to better serve the client. In support of this social worker role, current research demonstrates well-executed case management improves outcomes for clients while reducing costs.

Keywords: Proactive Case Management; social work engagement; silos of service; empowerment; models of case management; defense mechanisms

Introduction

Case Management Defined

Case management is defined as a client-centered, assessment-based interdisciplinary approach to integrating health care and social support services by assessing individual's needs and preferences, developing a comprehensive case plan, managing services, monitoring and reassessing services as needed by identified case manager following evidence-based standards of care. In addition to core elements of case management, the case manager provides disease management education, medication reconciliation, facilitation of sub-specialty referrals, and transitional care interventions. Case management activities include:

- Actively seeking eligible patients with significant health problems;
- Educating patients/families on the benefits of preventive health care services and following a medical regime prescribe by a physician;
- helping patients/families maintain a medical home and efficiently using health resources
- Assisting patients/families in accessing needed medical services and providing; and, psychosocial linkages/interventions to reduce barriers to health and well-being.

Review of Literature

Historically, case management has been a professional activity in the United States since Samuel Howe founded the Massachusetts School of Idiotic and Feebleminded Youth in 1848 (Weil & Karls, 1985). During this time, case managers tracked client's progress and individualized treatment of institutionalized children with disabilities (Trustees, 1920). As demands for services expanded, out-patient clinics were established with the development of aftercare case management. At the turn of the century, two progressive thinking women – Jane Addams and Ellen Start founded Hull House. They bought an older home on Chicago's West side and brought case management to the community and away from institutions (Addams, 1910). Adding to the science of case management, Mary Richmond developed the concept of social diagnosis during her work with immigrants (Richmond, 1919). In addition, she championed the belief that case work was individualized with unique solutions and conditions for the successful resolution of problems (Lieberman, 1990). World War I and II utilized the American Red Cross (The Home Service Corps) to help case manage the far away soldier and the stateside family (Dulles, 1950). The idea that a case manager would follow a case and act as a broker was developed during this time (Dulles, 1950; Hurd, 1959). In the mid-1960's several key pieces of Federal legislation were enacted, requiring case management and other various forms of social services.

Specific language in The Older Americans Act and other Federal legislation such as SSDI and SSI continued to develop the craft of case management (Rubin & Roessler, 2001). During the 1970's to 1980's additional Federal legislation such as The Rehabilitation Act of 1973, The Children with Disabilities, Education for all Handicapped Children Act of 1975, The Family Support Act of 1988, and the Personal Responsibility and Work Opportunity Act of 1996 continued to add further development to the collaborative model of case management (Jackson, Finkler, & Robinson, 1992). Finally, the development of fee-for service – or managed care as outlined in the Health Maintenance Organization Act of 1973 are seen as contributing events that sculpted case management as it is known today (MacLeod, 1993). Within the twenty-first century, the single largest attempt at health care reform was enacted under the Affordable Care Act (ACA). According to Commission for Case Manager Certification (CCMC, 2011, p. 2): “The way many providers are paid fails to align incentives to coordinate care in the outpatient, inpatient, home and post-acute settings and, in fact, may serve as a deterrent to effective care coordination.” Notwithstanding the many reforms of the ACA, it also illuminated the tremendous gap in services and the need for the Proactive Case Management Model discussed in this article.

While the places and reasons for case management activities occurred varied over the centuries, the purpose remains perennial: to improve client functioning. Initially, case management was focused on discharge planning for an acute hospitalization (Weil & Karls, 1985). Now, with the cost of health care reaching \$2.7 trillion dollars, growing at 3.9 percent (CMS, 2013), case management is seen as the ‘medical whisperer’ for out of control health care costs and medical service delivery operating in silos (Woodside & McClam, 2013).

Types of Current Case Management Models

The following three models of modern case management highlight the flexibility of the service delivery and the uniqueness of service tailored to outcome goals.

1. **Role-based Case Management** (also known as Collaborative or Integrated Care Model): This model of case management focuses on the role the case manager is expected to perform. The common roles include but are not limited to: a) Advocate; b) Broker of services; c) Coordinator of Services; d) Counselor; e) Planner; f) Problem Solver; and g) Record Keeper (Woodside & McClam, 2013).
2. **Organization-based Case Management** (also known as Point of Service): This goal of this model of case management is to provide a comprehensive set of services meeting the requirements and needs of clients with complex problems. Often, this model is seen in large agencies such as Public Health, hospitals, comprehensive medical service clinics, and psychosocial and medical rehabilitation centers (Woodside & McClam, 2013). Within this model of case management, two different approaches emerge dealing with primary care for the chronically ill: a) Transitional Care Model developed by Mary Naylor (Naylor, 2004); and, b) Comprehensive Care Management (Brown, 2009; Counsell, Callahan, Clark, Tu, Buttar, Stump, Ricketts, 2007; Counsell, Callahan, Wanzhu, Stump, Arling, 2009; Dorr, Wilcox, Brunner, Burdon, Donnelly, 2008; Peikes, Chen, Schore, Brown, 2009).

3. Responsibility-based Case Management: The primary focus of this model of case management is the transferring of care from a professional to a non-professional. In this model, family, friends, volunteers, and communities are trained to continue services once professional care is terminated (Woodside & McClam, 2013).

Proactive Case Management Model defined

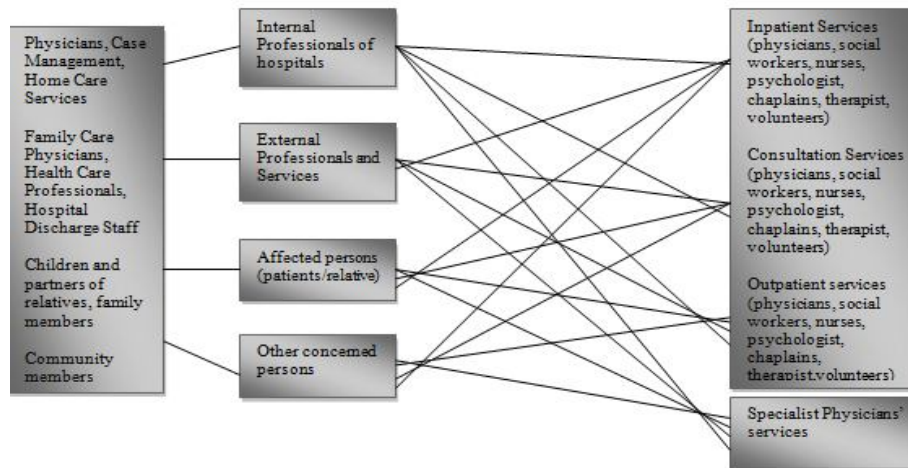
The 'client knows best' has its limitations particularly in areas of complex care. While the acknowledgment of insuring client-centered care with a focus on 'client knows their needs and wants,' the social worker should not abdicate their role in keeping a client in care or even partial care – particularly when this care involves the overall well-being of the individual and those within their ecosystem. Clients that are disenfranchised (literacy rates, income, insurance, and environmental factors) are truly not empowered or informed.

In Proactive Case Management the social worker must go beyond the silo of services provided by their agency to engage, educate, network, advocate, broker and facilitate the linkages for the individual. Social workers often miss the opportunity to engage the client in partial care. In many cases, service agencies will not allow partial care for the client. Examples of this are found in agencies that will not treat clients that are still using or still involved in serious self-destructive behavior. In addition, the move away from the medical and psychoanalytical models has left social workers untrained to understand transference and counter transference issues with difficult clients. The Proactive Case Management model revisits the need for skill sets often thought to be reserved for the therapist. The use of these skills sets further advance the ability of the social worker to assist the client. The lack of these skills on the part of the social worker often leads a client to not engage or disengage in treatment options. Due to complex and complicated access to many forms of care, the Social Worker must take on a proactive or anticipatory role – a role often seen in therapy. This form of services delivery does not fit current case management models. The following are recommendations of what is necessary to engage in effective Proactive Case Management:

1. Understanding unconscious defense mechanisms;
2. Understanding transference and counter-transference situations;
3. Use People First Language and common terminology (understand the literary level of your client);
4. Frequent contact with the client – including during transition and post transition;
5. Insure continuation of care outside of your agency;
6. Make appointments with client to other referrals;
7. Advocate for your client beyond your services and resources;
8. Make other agencies do their job for your client – it is not the other person's problem;
9. Anticipate issues (stratifying risks) – grow your services (what is the problem with a food bank or collecting coats, diapers or other things); and
10. Transportation will always be an issue – find a way outside the silo of services.

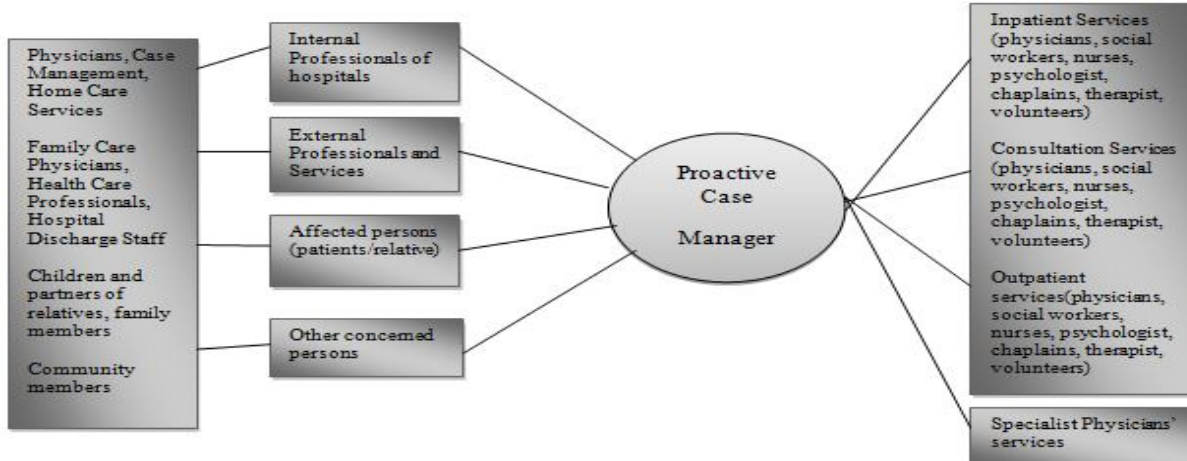
The following model represents a typical pre-case management chaotic service flow (Kuhn et al., 2012). As evidenced by the multiple access points and various ways to contact, request and receive services - not only is the potential of service replication high, losing information, losing staff member's time, and not delivering needed services is also a high occurrence.

Figure1: Depiction of service delivery without Case Management(used with permission, Kuhn et al., 2012).



The following Case Management Process Model (Kuhn et al., 2012) demonstrates the function of the Proactive case manager to assess, refer and organize services within a complex system that eliminates duplication of requests and streamlines service delivery.

Figure 2: Example of Case Management Process Model (used with permission, Kuhn, U. et al., 2012).



Cost-Effectiveness of Case Management

Over the past ten years, the interest in determining the efficacy of case management as a means of improving client outcomes, decreasing re-admissions (particularly 30 day readmits), stream lining service delivery, and containing cost has greatly improved the rigor of research – and results pertaining to the subject. The following model represents a typical pre-case management chaotic service flow (Kuhn, Dusterdiek, Galushko, Dose, Montage, Ostgathe & Volts, 2012). As evidenced by the multiple access points and various ways to contact, request and receive services - not only is the potential of service replication high, losing information, losing staff member’s time, and not delivering needed services is also a high occurrence.

As earlier stated, gleaning the merit and worth of case management within a system can be a difficult chase. Notwithstanding the difficulty, there is sufficient research that demonstrates the benefits of case management. A review of several (15) randomized trials in the area of community aged care conducted by You, Dunt, Doyle & Hsueh (2012) states:

This review provided largely consistent evidence that case management interventions improve older clients’ psychological health or well-being, and also delivered significant improvements in unmet service needs. (p. 11)

In further support of the benefits of case management, You et al., (2012) reviewed the first one thousand enquires in a newly established case management system.

This study showed:

...that case management service itself is accessible and that it facilitates access to other services and provider in the community. We are convinced that this service will result in an improvement of access to palliative care in the examined region. (p. 7)

A well-reviewed study evaluating the Community Care of North Carolina (CCNC) reported a savings of \$160 million annually (Steiner et al., 2008). The study highlights several key components of the Chronic Care Model utilized by CCNC (Steiner et al., 2008):

1. Linking patients to a medical home;
2. Engaging practices in quality improvement;
3. Case managing high-risk patients;
4. Planning interventions and measuring successes using quality data; and,
5. Providing a statewide structure but retaining regional control. (p. 362)

This study also offers a look at the challenges in dealing with implementing a Chronic Care Model (Steiner et al., 2008):

1. Per patient management fees may be insufficient to manage more complex patients;
2. Network expansion will incur more chronic conditions requiring more specialist;
3. Clinicians in busy practices have little time to meet and share treatment plans with a case manager;
4. Claims based on billing information are inadequate for defining and measuring successes; and,
5. Statewide protocols must be balanced with tailoring interventions specific to local community needs.

While the types of case management models and the client population may vary greatly, there is still a strong body of work demonstrating the benefits of case management. One example is a controlled trial test of a case management algorithm designed to reduce suicide risk among suicide attempters during six months after the first attempt (Vaiva, Walter, Arab, Courtet, Belleview, Demarty, Duhem, Ducrocq, Goldstein & Libersa, 2011). This study demonstrated two strategies of case management intervention showing a significant reduction in the number of suicide attempt repeaters. Two easily replicated and inexpensive methods - regular calls from a case manager and discharge information cards reduced repeat suicide attempts by 8% (Vaiva et al., 2011). Another example of case management success was reported by Chuang, Levine, & Rich (2011) studying 141 patients with COPD. This study evaluated the effects of patient education, frequent case management contact with the patient and a specific action plan for symptom exacerbation (Chuang et al., 2011). The results of this study showed an overall decrease in paid claims, an increase in primary care physician contact, and a downward trend in hospital admissions, bed-days and ER visits for the intervention group (Chuang et al. 2011). A unique study to determine if increasing services and nursing case management would decrease the number of chronically ill persons transitioning to full Social Security Disability found "participants increased their use of medically-appropriate services and had better long-term health outcomes" (Hall, Moore & Welch, 2011, p. 126). All of these studies found an increase in primary care physician contact but a decrease in more costly ER and in-patient bed-days with an over-all report of higher patient satisfaction and improved health outcomes. In fact, a study conducted by Ercan-Fang, Gujral, Greer & Ishani (2013) evaluated the perception of physicians concerning the benefits of case management in a population of 278 diabetic patients. The results were overwhelmingly positive in reference to physicians' perceptions (Ercan-Fang et al., 2013):

The majority of the providers felt very comfortable working with case managers (91.5%), found treatment provided by CM to be accurate (93.3%), reported that having case manager increased the likelihood of adherence to the treatment regimens (89.4%), and reported overall improved patient satisfaction with CM (93.5%). (p. 29)

Research studies done on particular models of case management also produce positive outcomes in the area of case management efficacy and consumer benefits. A study done on Point-of-care case management and its effects on readmissions and costs containment within a managed care group demonstrated a 34.84% reduction in readmissions for the intervention group, a 43.17% reduction in readmit bed-days, with a total annual savings of \$1,240,564.80 (Kolbasovsky, Zeitlin & Gillespie, 2012).

Research done on home-based intensive case management model focusing on the prevention of 3-year subsequent birth for low-income adolescent mothers showed a 14% reduction in subsequent birth as compared to the comparison group (Lewis, Faulkner, Scarborough & Berkeley, 2012). While not statistically significant, the practical significance and overall systemic savings of preventing an additional birth are extremely noteworthy. A longitudinal study on a community-based comprehensive case management model for children with Severe Emotional Disturbance (SED) and their families reported an annual savings of approximately \$50,000 per child (Green, Twill, Nackerud & Holosko, 2013). This study confirms what other studies measuring case management efficacy report: an increase in primary service use and a decrease in the more expensive in-patient and ER admissions. The study also reports increase family stability and increase in family income as a result of effective management of children with SED (Green et al., 2013).

An additional qualitative shelter-based intensive case management research study done by Davis, Tamayo & Fernandez (2012) demonstrated the benefits of the strong interpersonal relationship these patients had with their case manager. This relationship was the overwhelming self-reported key to recovery for homeless persons with mental health and substance abuse issues (Davis et al., 2012). Research done on the Transitional Care model of case management is reported to reduce re-admissions but - intuitively so, does little to improve long-term outcomes (Volland, Schraeder, Sheldon & Hess, 2013). On the other hand, the Comprehensive Care model of case management, due to its longer duration, results in increased satisfaction with service, quality of service, and self-reported quality of life (Boult, Green, Pacala, Snyder & Clair, 2009).

In summary, case management, when used effectively does improve the quality of life for both the patient and their family. In addition, case management lowers service delivery cost in a variety of settings across a variety of health issues. The Proactive Case Management model revisits the need for skill sets often thought to be reserved for the therapist. The use of these skills sets further advance the ability of the social worker to assist the client. Finally, this review of literature elucidates benefits and points of consideration for several case management models. The take-away seems to be the ability of social worker (case manager) to adequately meet the needs of the client in a particular system. The skill sets necessary in many complex medical situations mirror those often reserved for the therapist. Case management should not be left to the lesser trained or educated service delivery personnel; it should be considered a critical function requiring professional training and advanced skills to achieve beneficial client-centered outcomes.

References

- Addams, J. (1910). *Twenty years at Hull House*. New York. New American Library.
- Boult, C., Green, A., Pacala, L., Snyder, J., Clair, L., (2009). Successful models of comprehensive care for older adults with chronic conditions: evidence for the Institute of Medicine's 'Retooling for an Aging America' Report. *Journal of the American Geriatrics Society*, 57(12):2328-37.
- Brown, R. (2009). The promise of care coordination: models that decrease hospitalizations and improve outcomes for Medicare beneficiaries with chronic illness. Retrieved from: http://sociawork.nyam.org/nsw/care/Brown_Executive_summary.pdf. CCMC (2011) Center stage in the revolution: A health care reform action guide for the professional case manager. Retrieved from: ccmcertification.org/sites/default/files/downloads/2011/4.%20Center%20stage%20in%20the%20revolution%20-%20volume%202,%20issue%202.pdf
- Chuang, C., Levine, S. & Rich, J. (2011). Enhancing cost-effective care with patient-centric coronary obstructive pulmonary disease program. *Population Health Management*. DOI: 10.1089/pop.2010.0015
- Counsell, S., Callahan, C., Clark, D., Wanzhu, Buttar, A., Stump, T., Ricketts, G. (2007). Geriatric Care Management for Low-Income Seniors. *Journal of the American Medical Association*, 298(22): 2623-2633.
- Counsell, S., Callahan, C., Wanzhu, T., Stump, T., Arling, G. (2009). Cost analysis of the geriatric Resources for assessment and care of Elders Care Management Intervention. *Journal of the American Geriatrics Society*, 57(8): 1420-1426. DOI: 10.1111/j.1532-5415.2009.02383.x.
- Davis, E., Tamayo, A. & Fernandez, A. (2012). "Because somebody cared about me. That's how it changed things": Homeless, Chronically Ill Patients' perspectives on case management. *PLoS ONE* 7(9): e45980. DOI: 10.1371/journal.pone.0045980

- Dorr, D., Wilcox, A., Brunner, C., Burdon, R., Donnelly, S. (2008). The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors. *Journal of the American Geriatrics Society*, 56(12): 2203-2210. DOI: 10.1111/j.1532-5415.2008.02005.x.
- Dulles, E. (1950). *The American Red Cross*. New York. Harper.
- Ercan-Fang, N., Gujral, K., Greer, N. & Ishani, A. (2013). Providers' perspective on diabetes Case management: a descriptive study. *American Journal of Managed Care*, 19 (1): 29-32.
- Hall, J., Moore, J. & Welch, G. (2011). Preventing disability among working participants in Kansas' high-risk insurance pool: Implications for health reform. *Journal of Vocational Rehabilitation*. DOI: 10.3233/JVR-2010-0549.
- Hurd, C. (1959). *The complete history of the American Red Cross*. New York. Hawthorne.
- Green, D., Twill, S., Nackerud, L. & Holosko, M. (2013). An ecological approach to evaluating a System of Care: Dollars making sense. *Journal of Evidenced-based Social work*.
- Jackson, B., Finkler, D., & Robinson, C. (1992). A case management system for infants with chronic illness and developmental disabilities. *Children's Health Care*, 21(4): 224-232.
- Kolbasovsky, A., Zeitlin, J. & Gillespie, W. (2012). Impact of Point-of-Care Case Management on Readmissions and Costs. *The American Journal of Managed Care*, 2012; 18(8):e300-e306.
- Kuhn, U., Dusterdiek, A., Galushko, M., Dose, C., Montag, T., Ostgathe, C. & Volts, R. (2012). Identifying patients suitable for palliative care – a descriptive analysis of enquiries using a Case Management Process Model approach. *Biomedical Research Notes*. <http://www.biomedcentral.com/1756-0500/5/611>
- Lewis, C., Faulkner, M., Scarborough, M. & Berkeley, B. (2012). Preventing subsequent births for low-income adolescent mothers: an exploratory investigation of mediating factors in Intensive Case Management. *American Journal of Public Health*. DOI: 10.2105/AJPH.2012.300914
- Lieberman, F. (1990). The immigrants and Mary Richmond. *Child and Adolescent Social Work*, 7(2): 81-84.
- MacLeod, G. (1993). An overview of managed health care. In P. Kongstvedt (Ed), *The managed health care handbook* (pp. 1-3). Gaithersburg, MD: Aspen.
- Naylor, Mary D.; Brooten, Dorothy A.; Campbell, Roberta L.; Maislin, Greg; McCauley, Kathleen M.; Schwartz, J. Sanford. Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. *Journal of the American Geriatrics Society*. May 2004, Vol. 52 Issue 5, p675-684. 10p. 7 Charts. DOI: 10.1111/j.1532-5415.2004.52202.x.
- Peikes, D., Chen, A., Schore, J., Brown, R. (2009). Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries. *Journal of the American Medical Association*, 301(6): 603-618.
- Richmond, M. (1919). *Social diagnosis*. Russell Sage Foundation.
- Rubin, S., & Roessler, R. T. (2001). *Vocational rehabilitation process*. Austin, TX: PRO-ED.
- Steiner, B., Denbam, A., Ashkin, E., Newton, W., Wroth, T. & Dobson, A. (2008). Community Care of North Carolina: Improving Care Through Community Health Networks. *Annals of Family Medicine*, 6:361-367. DOI: 10.1370/afm.866.
- Trustees of the Massachusetts School for the Feeble minded (1920). *Seventy-third annual report*. Boston: Wright and Porter.
- You, E., Dunt, D., Doyle, C. & Hsueh, A. (2012). Effects of case management in community aged care on client and career outcomes: a systematic review of randomized trials and comparative observational studies. *BMC Health Services Research*, 2012, 12:395. <http://www.biomedcentral.com/1472-6963/12/395>.
- Vaiva, G., Walter, M., Arab, A., Courtet, P., Bellivier, F., Demarty, A., Duhem, S., Ducrocq, F., Goldstein, P. & Libersa, C., (2011). ALGOS: the development of a randomized controlled trial testing a case management algorithm designed to reduce suicide risk Among suicide attempters. *BMC Psychiatry* 2011, 11:1. <http://www.biomedcentral.com/1471-244X/11/1>.
- Volland, P., Schraeder, C., Sheldon, P. & Hess, I. (2013). The Transitional Care and Comprehensive Care Coordination Debate. *Journal of American Society on Aging*, 2012-13, 36(4): 13-19.
- Weil, M., & Karls, J. (1985). Key components in providing efficient and effective services. In M. Weil & J. Karls (Eds.). *Case management in human service practice* (pp. 29-71). San Francisco: Jose-Bass.
- Woodside, M. McClam, T. (2013). *An Introduction to Human Services (7th Ed.)*.
- Brooks/Cole: Ca. www.cms.gov/Research.../National Health Expend Data/.../Proj2011PDF.pdf