CASE MANAGEMENT: COOPERATION AMONG DISCIPLINES
A SOCIAL WORK PERSPECTIVE

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Medical cost containment, of which case management is a part, is estimated to be a $7 billion industry in the United States.¹ While case management provides no direct care, it serves to facilitate appropriate, cost-effective access to finite health care resources. Private, state, and federal payors are ever vigilant to find creative ways to coordinate care and contain costs for high-risk populations.

Case managers act as gatekeepers, resource managers and decision makers for billions of dollars worth of care annually. Various professions vie for leadership because case management is such a growing and important function due to increased demand for services and the need to reduce and manage costs. Each discipline perceives theirs as uniquely suited to manage complex cases. Those professions include physicians, social workers, nurses, and vocational rehabilitation specialists.

While the physician is the ultimate case manager because of their role in authorizing treatment and medications, most physicians have high demands on their time and may have limits in their knowledge of access to services and funding resources.

These realities mandate the need for others, be they social workers, nurses, or other disciplines, who have the necessary skills to perform the case management functions.

Just as there is a continuum of care in the recovery from a catastrophic physical injury, there is a continuum of core case management functions and skills needed to ensure care is appropriate and cost-effective. This article will discuss how social workers, as case managers, utilize their unique training and perspective in mobilization and creation of scarce, critical resources.

Historical Overview

The roots of case management in the United States can be traced back as far as 1863. Immigrants and poor families had basic survival needs—food, clothing, shelter, and education. Needs were many and resources were sparse.

In Jane Addams’s Hull House, case management was practiced by social workers. Their identification of the social and neighborhood problems of families in terms of the need for care and growth included assessment of available support systems and resulted in the mobilization of community resources to meet those basic needs. Social service pioneers such as Mary Richmond, Jane Addams, and Joseph Tuckerman established the patient and the goal of self-sufficiency as the central focus for case management.²

Case management, then, is the foundation of social work as a field of practice and utilizes the social work traditional methods of casework, group work, and community organization. “Case manager” is the contemporary name for a case worker.

Growing Need

Today’s physically disabled have much in common with the immigrants and the poor who spawned the development of case management nearly a century ago. The physically disabled are a vulnerable population. “Vulnerability refers to conditions that limit the opportunities or independence of clients [patients] or that shape their basic life-style.”³

For the 32 million Americans with a physical disability,⁴ the 1990s and beyond promise ever-decreasing funds for their ever-increasing care needs. Current fiscal limitations in health care make efficient service coordination and delivery essential.

Definitions Differ

From its inception, the concept and process of case management has been fraught with conflict. Among present practicing case managers, there is little agreement as to definition, professional credentials, necessary skills, ethical standards, accountabilities, or primary setting for case management.

One definition of case management’s goal is:

“Case management . . . seeks to establish an integrated set of functions that helps individual clients [patients] obtain services when they are needed or to press for services that do not exist or are low in quantity or quality in order to establish a viable comprehensive continuum of care.”⁵

Core Functions

While no universally accepted definition of case management exists, there is undeniable recognition of the continuum of functions necessary to achieve an effective outcome and contain the skyrocketing costs associated with catastrophic injury. There are eight principal components of case management, from a social work perspective, which will be discussed in detail below.

These core functions are (1) patient referral; (2) individual assessment; (3) resource identification and planning needed services; (4) linking the patient to needed services; (5) service implementation and coordination; (6) monitoring; (7) advocacy; and (8) evaluation.
Patient Referral

Patient referral is largely a function of outreach to an identified patient population. The setting employing the case manager usually dictates patient referral. For example, patient referrals for a case manager working for a hospital would come from the inpatient and outpatient populations. Case managers are now employed by federal, state, and private insurance carriers; by hospitals, physicians, and other service providers; by attorneys; and even by families who need assistance to access services and reimbursement.

Assessment

Social work sees the patient as they relate to all parts of their system— their family, friends, work, and community.

“Current conceptual frameworks for social work practice, with their underlying focus on the person-in-environment interface, suggest that a compelling case can be made for social work leadership in implementing and advancing case management in its broader context.”

This global systems approach makes it possible to maintain a broad perspective of the complexity of the patient’s problems. The systems perspective prevents the “zoom lens” effect of only focusing on the immediate care needs of the patient and excluding the ever-changing impact on other parts of the system. Like the mobile in a baby’s crib, all parts of the system must move in response to one part being affected.

Assessment of the patient’s needs is multi-diagnostic. In the initial treatment phase, when the patient has high physical care needs, medical knowledge and skills are essential to recommend appropriate levels of treatment. Assessment, however, is an ongoing process, constantly shifting focus from the micro—the patient’s immediate care needs, to the macro—the patient’s environment and its ability to meet those care needs.

Case managers must be able to adjust the level of care and support, through assessment and interfacing with the patient, their environment, and their caregivers. In some respects, catastrophic injury is more difficult for family members as they cope with their own daily demands and the needs of their injured loved one. Psychosocial stressors may escalate and build one on top of another as care needs increase.

Patients who reach acute rehabilitation may have almost a normal life expectancy. Even in the best case scenario, catastrophic disability is likely to provide unbearable family stress. The divorce rate for head injury survivors is estimated to be two to three times higher than the national average.

Adult children frequently become the responsibility of aging parents. Awareness of life cycle limitations, and how the family copes with stress are extremely critical factors when weighing the feasibility of any plan.

Resource Identification and Planning Needed Services

According to Alvin H. Arakaki, a noted expert in the field of case management:

“Effective case management must include the expectation that the patient will encounter difficulties and there will be setbacks. These inevitable setbacks necessitate preparation of a safety net of resources to minimize the damage to the patient and get the recovery process back on track.”

Resource identification is insufficient in contingency planning. Access to resources is dependent on reimbursement for those services. Clear knowledge of the patient’s continuum of care needs and the extent of their support system is essential to effectively articulate ongoing costs and strategies for long-term savings to the funding source.

It is a given that reimbursement for services is rarely, if ever, sufficient, whether from private carriers or from federal and state entitlement programs. Linking the patient to needed services makes understanding the nature of the reimbursement bureaucracy crucial.

Almost more important than the insurance policy’s fiscal limits are payors’ limits in detailed understanding of effective treatment for a specific diagnosis. Long-term cost savings are most possible through timely and effective mobilization and interface of funding and care systems.

Payors have limits in their liability. They may do their members a disservice and ultimately cost themselves more money by a lack of understanding of the sequela of the catastrophic injury and the potential to reduce re-hospitalization by early and effective treatment. Obtaining authorization for services includes education of the payor combined with skill in winding the way through the bureaucratic maze.

Case managers must perform a delicate balancing act to combine the demands of quality service coordination and cost-efficient use of available resources. Planning needed services involves not only knowledge of existing community resources but also development of resources if necessary. Organizational skills are also required to develop an optimal sequence of care to meet the patient’s needs within fiscal resource limits.

Linking the patient to needed services

Once a plan has been developed and the needed services and appropriate service providers identified, the next step is to link the patient to those services. Linking the patient to needed services is not simply making a referral—“It requires doing whatever is necessary to get the [patient] to the service.”? The case manager makes the initial contact with service providers, coordinating, negotiating, and mediating services.

To ensure the patient is linked to the services, the case manager may facilitate transport to the service agency or even participate in the other agency’s intake process. How the patient connects with the services determines the tone of their ongoing interaction and leads to the ultimate success or failure of the intervention.

Service Implementation and Coordination

Implementation, simply stated, is following through on the plan— getting the services delivered to the patient. Coordination includes ensuring the plan is carried out and is in accordance with agreements made for the patient’s care.

Implementation and coordination include evaluation of the effectiveness of the link to the patient and assessment of the benefit of the services.
Time lines for implementation and coordination may span a few months or years, depending on the patient's care plan and lifetime needs. Coordination frequently is thought of as “troubleshooting” and can range from the mundane to the complex. “Getting all the pieces of the service plan in place so that they are carried out in a logical sequence is the heart of service coordination.”

**Monitoring**

Monitoring service delivery is described as assessment of the appropriateness, quality, and patient benefit from the services. This requires working closely with the patient, the patient’s support system, and the service providers.

Case managers span the boundaries between the client and the various service providers. They oversee service delivery by individuals they do not supervise. Giving case managers purchase-of-service power has been suggested as one method to facilitate intervention and quickly get services back on track when necessary.

**Advocacy**

Advocacy, acting in support of another, is done at the individual case level, by supporting the best interests of a particular patient. Advocacy is also used at the systems level, by recommending and working toward changes that will benefit the entire “vulnerable” population.

Advocacy is usually employed when efforts to coordinate and collaborate have not produced the desired results. Conflict management skills are used when negotiating differences between systems, expectation of outcome, and patient limitations.

Social work community organization literature supports the principle of least contest. “Least contest” means to effectively advocate for patients rights without “destroying the collaborative system needed to execute case management.”

Approaches to advocate for the patient range from education, to persuasion, to bargaining, to campaign tactics, and, finally, to direct-contest tactics. This approach uses a productive, less damaging tactic, i.e., education, first. Direct-contest tactics are used only when all other efforts have failed.

It is in the interest of the patients, the service providers, and the case managers to maintain ongoing positive working relationship. Clearly, when disharmony or contention exists between various disciplines who perform service delivery or case management functions, damage is done to the patient, the case managers, and all parts of the system.

**Evaluation**

Evaluation, like assessment, is an ongoing process. Case managers are charged with the responsibility of collecting, analyzing, and distributing information about the patient and the effectiveness of the services being delivered.

The reports generated from this data collection serve critical functions for the case manager, the patient, and the payor. Reports can keep the services focused and on track, revise the service plan as needed, identify and resolve problems, and determine when services are no longer necessary.

**Essential Skills**

Clinical, assessment, and advocacy skills are necessary to perform the continuum of quality case management functions. Other critical skills include problem solving, decision making, and conflict resolution. Possibly the skill most essential, however, is a high level of interpersonal ability to build rapport with the myriad of people necessary to obtain an effective continuum of quality care for each patient.

**Conclusion**

The balance between the needs of the patient, the quality and availability of services, and the limits of financial resources is not an easy one to maintain. Time constraints and administrative demands are daily realities which can affect the “balance.”

Frequently, case managers are expected to be all things to all people. Just as it is impossible to be all things to all people, it is impossible for any one discipline to provide the full continuum of case management services needed from initial trauma through completion of care. Physicians, social workers, nurses, vocational rehabilitation specialists, and others have their place in providing case management.

As case management refines and develops as a distinct profession encompassing multiple specialties, it will be necessary to utilize each discipline’s expertise for the benefit of the patient. The ability to provide quality case management—to facilitate patients receiving timely, appropriate, cost-effective services—requires a person with a high level of skill and is not discipline specific.

**REFERENCES**

11. Ibid.:36-37.