

Towards a Typology of Case Management

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Case management is a term whose definition has defied consensus. Since the emergence of case management as a model of practice in community social service settings, the literature has attempted to formulate a comprehensive, universal description applicable in a variety of fields with various populations. However, the term itself has been widely applied across professions and practice settings making agreement on a definition a complex undertaking (Moore, 1992, Rudolph, 1998, Austin, 1993, Peterson, et. al., 1997). This paper reviews some current models of “case management” performed by “case managers” with the intent of proposing a basic model of service delivery as well as definitions of persons who deliver that service.

Historical Overview

Modern case management, or the casework practice area of social work, is said to have originated with Griscom’s Society for the Prevention of Pauperism in 1820. The Society’s goals were to investigate the habits and circumstances of “the poor,” to suggest plans by which such people could help themselves, and to encourage them to save and economize (Zastrow, 2000). In the late 1870s the Charity Organization Society (COS) model was imported into the United States from England. These organizations provided direct services and assisted private agencies by in addressing the increasing social problems related to the rural-to-urban population shift. COSs used volunteer “friendly visitors” who, with encouragement and smiles, called on people who were poor.. A more centralized model of service delivery began with the emergence of the settlement house movement at the turn of the century. Then, in 1917 Mary Richmond’s *Social Diagnosis* gave the nascent social work discipline its first scientific text to present a theory and method of assessment (diagnosis).

The prevalence of the Freudian psychotherapeutic model of diagnosis and care during the next several decades shifted the mental health emphasis from external to intrapsychic processes, and casework, as it had begun to emerge as a social model, fell into disuse. Clients became psychiatric “patients,” and many were housed in large mental institutions.

The deinstitutionalization movement in the 1960s shifted the locus of mental health care from the state psychiatric hospital to community services. By the mid 1970s it became evident that existing services were fragmented and ill equipped to handle the multiple needs of persons with mental illness living in community settings. With encouragement and funding provided by the National Institute of Mental Health (NIMH), the Community Support System was initiated to address the need for community-based services. Case management was included as one of the primary components of the Community Support System and public law 99-660 mandated case management services for persons with mental illness.

Case management was viewed as a cost-effective way to coordinate care for people with mental illness by linking them to needed service providers. Case managers helped clients navigate the newly formed and fragmented community mental health system. In addition,

case managers assisted clients in obtaining basic services like food and shelter that were once provided by the state psychiatric hospital. Largely due to the belief that case management was a cost-effective means of providing care, the term began to appear in a number of federally mandated acts specifying the need for community-based services (Netting, 1992). The Omnibus Budget Reconciliation Act of 1981 instituted case management as a service for a number of vulnerable population groups, including elders and people with disabilities, under the Medicaid Home and Community-Based Waiver Program. In this legislation case management was defined as “the coordination of a specified group of individuals” (Austin, 1993, p.452). The definition was purposely left broad in order to allow individual states ample latitude in determining the specific functions of the case management role.

In the 1990s case management came to be viewed as the coordination of care across a system of service providers to meet the needs of a particular client or client group (Kuno et al., 1991, Moore, 1992, Draine, 1997, Austin, 1993). General agreement exists concerning the primary activities carried out by case managers. These are as follows: assessment of clients needs, service planning, linking clients to services, monitoring service delivery, advocacy, and continued evaluation of client needs (Kuno, et. al., 1991, Huxley, 1993, Rudolph, 1990). Problems arise when we attempt to apply this definition to actual models of case management practice. On close inspection particular models of care become increasingly complex. While each model may include some of the primary activities, actual tasks and functions of case managers vary depending upon the needs and goals of the agency and the client population it proposes to serve. In other words, the population being served guides and informs the model of service delivery, which in turn shapes the roles and functions of case managers. Therefore, while general duties and activities appear across a broad spectrum of case management models, individualized differences reduce the possibility of a comprehensive definition. Nevertheless, researchers have continued to try to agree on primary models of case management. By identifying a finite number of paradigms, it may be possible to limit the scope of the term and clarify what elements in case management yields the best results in outcome studies (Moore, 1992, Austin, 1993, Rudolph, 1990, Peterson, et. al., 1997).

Contemporary models of case management

A number of case management models have been recognized in the literature that “can be classified according to target population, auspice, purpose, setting and roles performed” (Netting, 1992, p. 161). More than a dozen different models (including medical, social advocacy, managed care, outreach, ecological, intensive and clinical) have been noted in the academic journals. Four comprehensive categories distilled from these models are presented here. They are: the Broker, the Rehabilitation, the Full Support, and the Strengths models (Williams et al., 1998).

The primary function of the Broker model is to link the client to needed, usually external, resources. Case rations are usually high and one case manager is responsible for the client needs assessment and for carrying out the treatment plan. This model limits the role of the case manager and client relationship. The main task is to identify what the client needs and then to facilitate the referral so the client is connected to the service provider.

Once this task is accomplished, the case manager's function is complete. The model relies on the case manager's assessment abilities and knowledge of community resources. The literature shows that this is the least effective model, due to its minimal involvement with the client and the lack of follow through to ensure that the clients needs have been addressed (Rapp, 1998).

The Rehabilitation and the Full Support models utilize the relationship between the case manager and the client as a means to facilitate and secure service provision. The Rehabilitation model identifies strengths and deficits of the client and attempts to remedy a wide array of problems and barriers that may include medical, mental health, vocational and housing issues. The case manager's role is to assist the client in overcoming barriers that prevent independent functioning in the community. When barriers have been addressed, the relationship between the case manager and the client is reduced or terminated.

The Full Support model expands upon the Rehabilitation model by using an integrated treatment team of providers. The team is comprised of case managers, outreach workers, rehabilitation specialists, and medical professionals, including a psychiatrist. This model relies less on outside referrals and uses an in-house treatment team to provide the client with a focal point of service delivery. The case manager in this model not only coordinates care but also provides clinical support and life skill training. The Full Support model has been shown to reduce inpatient psychiatric hospitalizations and is generally used with clients who have long-term care needs. The relationship between client and the treatment team is open-ended and ongoing rather than limited to specific goals (Draine, 1997). Thus, it is more difficult to evaluate and determine when to terminate direct care.

A relatively new model of case management that has been widely commented on in the literature is the Strengths model developed by Charles Rapp. As the name implies, the Strengths model steers away from an assessment of needs based on client pathology or deficits. The focus is exclusively on client strengths. Self-determination of the client and assisting the client in attaining client-specific goals are the task of the case manager. This model puts a strong emphasis on the case manager-client relationship. It depends on intensive outreach and follow up with clients to ensure follow through and access to providers of care (Standard, 1999, Rapp, 1998).

While categorization systematizes a large number of models, there are still several problems that prevent a comprehensive definition of case management. Some organizational models of case management are largely administrative. Rather than facilitating client transactions with services, these models are designed to minimize utilization of services, or make utilization more efficient from the agency point of view. Such a model is frequently found in managed care organizations that use nurse or other case managers as gatekeepers between the client and service provision, with the goal of cost containment (Huxley, 1993, Austin, 1993, Williams, 1998, Netting, 1992). Rapp points out that the problem with such models is that they are difficult to replicate; each agency adapts the model to meet its own objectives. In doing so, they alter the model which makes determining its most effective elements difficult to assess. Rapp describes

another problem with models that he calls “model mentality.” This occurs when agencies use similar models, but highlight their differences in an attempt to emphasize their uniqueness. Agencies that use a certain model may be resistant to facilitating linkages to other organizations because they fear this external involvement will undermine their authority. This approach increases fragmentation already present within the system.

The social work profession has tried to define its own model based on social work practice. Moore views case management as a new term for what was once called “casework.” Moore notes that in a social work model of practice, case management must be removed from its administrative, or restrictive, function and placed along an axis of enabling and facilitating. The role of case manager is to enable the client to reach self-determined goals while at the same time to facilitate client links with the social environment and the family (Moore, 1990; Dinerman, 1992). The case manager becomes the person who coordinates care between formal systems (agencies) and informal systems (the client’s family or support network). Viewing case management within this frame, according to Moore, adheres closely to Germaine’s (1979) ecological model of “person in the environment.” Moore notes that when resources are limited, informal supports are increasingly called upon to fill in the gaps that service organizations cannot fill (Moore, 1990).

The National Association of Social Workers (NASW) has standards for case management practice. These standards reflect the values that the NASW holds as core essentials of social work practice. Like many other models, the NASW standards maintain a client-centered approach. However, even within the social work profession, the attempt to define case management has resulted in further disagreement about the term. For example, should people who do case management have a social work education? Should that education be at the bachelor’s or master’s level? Is case management a discipline grounded in social work practice, or is it a separate discipline that is often, but not exclusively, performed by social workers? Is case management as practiced by social workers inherently different from case management practiced by nurses or other human service professionals and paraprofessionals?

Historically a case manager coordinated services because presumably s/he knew the community resources better than the client did, and could facilitate the coordination of those resources. This was done with the goal of comprehensive service delivery for the improvement of the client. We have said little about efficiency in such a model because we may have assumed that coordination is inherently more efficient than duplication of services or the delivery of services with conflicting goals. However, we must now note that the coordination of services is inherently more efficient for the client, certainly, but it may be more difficult to demonstrate efficiency for the agency. In the era of cost containment, agencies are now expecting the coordination of services to be more cost effective for themselves. Evaluation of case management services is an area beyond the immediate scope of the present paper. However, in evaluating case management services it is important to look beyond the simple delivery and/or coordination of services to a specific client. Evaluation of all the costs associated with client positive outcomes, such as adherence to appointments and medications, as well as costs saved by decreases in

negative outcomes such as the number of emergency room visits, or psychiatric crises, incidents of violence or arrest, substance abuse, etc. must all be considered in evaluating the effectiveness of case management. Intangibles such as an increase in a client's overall wellness, sense of well-being and competence, while difficult to measure, are essential social work outcomes.

We can conclude from the literature regarding the definition of case management that historically the term encompasses a broad array of functions whose core task is the coordination of services. This is the trunk of the case management tree; the various branches are the way each agency limits or expands the tasks of the case manager to target the specified population or condition. Administrators understand case management as a cost saving measure that is an "inherently conservative activity that has been widely accepted because it does not pose a serious threat to the status quo" (Austin, 1993). Huxley notes, however, "While judgment of its value in other terms is not inappropriate, [case management] should be assessed in terms of its purpose, goal and effectiveness, not in terms of its capacity to meet the requirements projected on it by others" (Huxley, 1993). In other words, case management is a specific discipline that must not be allowed to become the sum of the expectations of agency workers, clients or administrators.

HIV case management

Case management for a person with HIV disease illustrates some of the difficulties involved in creating a consistent definition for case management. Because HIV is a relatively recent phenomenon, the literature of social case management for people with HIV is sparse. The articles that exist speak to the unique aspects of providing case management services to this population. As with other case management models, there are core functions of an HIV case manager (Indigle, et. al., 1993). However, based on the multiple challenges faced by persons affected by HIV, the case manager must be able to rely on skills and a knowledge base that encompasses sensitivity to the psychosocial issues of drug use, chronic illness, poverty and discrimination (Piette, et. al., 1992). In many HIV service agencies, more weight is placed on the experience of "case managers" with populations affected by HIV than with academic or theoretical training in social case management. In other words, while certain core tasks remain constant for HIV social case managers, much of their work and their knowledge base centers on the client population they are serving. Therefore, HIV case managers currently apply generalist skills within an area of specialization that reflects their client base.

Worker definitions

Furthermore, within the history of case management, and HIV social case management in particular, we find a confusion of many different practice terms: case manager, case worker, case aide, case assistant, nurse case manager, social worker, and doubtless others. It is this proliferation of terms and models that has led many funders to develop and require basic elements of practice. We propose the following nomenclature:

- Caseworker: a generic term for anyone who has direct responsibility for assisting a client using a social casework model. This term is not appropriate for medical case

management of a patient by a nurse.

- Case aide, or case assistant: an individual, generally a peer, with at least a high school diploma or equivalent, who has special training or experience with a specific target population. The case aide is trained to deliver or refer a more or less predetermined range of services. This aide is best used with the supervision of an experienced case manager or social worker because the case aide is generally less prepared to do client assessments and social diagnoses outside his/her area or population of expertise.
- Case manager: an individual with at least a bachelor's level education, and/or who has undergone specific training by a recognized case management training authority. The case manager is responsible for carrying out a comprehensive client assessment using an approved tool, and for the provision of or coordination of a range of services by referral or preapproved protocol to a specific and limited number of individual clients.
- Social worker: a professional with at least a master's level preparation in social work and social welfare, who supervises case managers, and who may maintain a limited case load of clients with specialized service needs. The social worker is responsible for a comprehensive client assessment and the provision of a broad array of services as the social worker determines. The social worker is also chiefly responsible for the development of an interdisciplinary service and treatment plan, and for evaluating the efficacy of the plan.
- Nurse case manager: a registered nurse or licensed vocational nurse who is responsible for the outpatient medical case management of a patient. Normally this will include medications and medication administration (such as infusions), appliances, and assessment of a household to reduce the physical challenges facing a physically compromised patient. The nurse case manager should coordinate with a social case manager so that all areas of a client's environment are assessed and addressed in the service and treatment plan. The nurse case manager may also be the "gatekeeper" to other medical services such as specialty or inpatient care or complex therapies.

Conclusion

Case management was implemented as the primary intervention to meet multiple needs of disabled populations living in the community whose access to institutional care was severely curtailed. The belief was that resources were available in the community and the worker would only need to overcome the fragmentation of service providers in order to meet the needs of people with mental illness and other disabilities, children and elders. Unfortunately, along with the proliferation of case management programs came a decrease in resources provided by the Federal government to the state run service organizations. This led to a large gap between the intention of case management models and their ability to deliver on their mandate. To deal with these dilemma newer and expanded models were invented. The specific functions and roles that case managers were expected to perform increased in scope and dimension. The term remained constant but the responsibilities of case managers began to differ along a wide continuum of care. The role of the case manager expanded as the funding contracted, leading to an over-

reliance of agencies to provide the structure and care needed to maintain clients in the community. This fueled the hope and the subsequent projection that case management, as the lynchpin in community care, would somehow overcome all obstacles and provide a cost effective alternative to hospital or institution-based services.

Case management is a service that is here to stay. It has developed a vital role in the lives of those requiring coordination of care and it is an essential part of the entire system of human services. Perhaps it is the lack of definition that has allowed case managers the freedom and flexibility to interact with clients on multiple levels of care. Providing the type of care that expands beyond the medical, psychiatric or therapist's office is aligned with the ethics and values that define contemporary social work practice.

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