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Practice concept

Co-ordinating community care of the aged through case management

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Abstract

The co-ordination of service delivery to chronically ill and severely impaired persons in community settings is a major problem facing human-service organizations. In the United States case management evolved as a synthesis of the co-ordination of direct service delivery to clients and between service-delivery systems. Case management thus has a dual nature: (1) Direct service delivery which is continuous, co-ordinated and based on planned intervention to ensure the rendering of quality care to a client; and (2) the administrative structure, inter-organizational networks, and informal and formal resources within which case management takes place, and which aims at accountability and cost-effective utilization of resources. A practice model of case management in aged care should include the following components: Assessment; the planning of services and the identification of resources; linkage between clients and resources; implementation and co-ordination of services; the monitoring of service delivery; and evaluation and re-assessment. A model for monitoring case management in aged care is presented. As South Africa is in the process of replanning and restructuring its service-delivery system, the usefulness of case management to co-ordinate community care of older persons should be considered.

Introduction

The co-ordination of service delivery to chronically ill and/or severely impaired clients in community settings has been an ongoing problem in human-service organizations. This problem was compounded by certain trends that evolved during the past three decades. First, advances in medical science(s) have caused what Brody (1985: 20) calls the "second demographic revolution," i.e. a marked increase in the number of persons aged 75+ years. Health advances have enabled physically disabled persons to remain in, or return to community settings. In addition, advances in pharmacology have made it possible to stabilize symptoms of mental illness and have enabled mentally ill patients to remain in the community. Second, a policy shift away from institutional care to community care has required that continuing care be extended to chronically ill or impaired clients in community settings. A substantial category of dependent clients who require sustained attention from a variety of service professionals evolved. Third, the subsidization of welfare services on a programme basis has led to the rapid expansion of human-service programmes. Rothman (1991: 520) describes the situation in the US as follows: "The service delivery 'system' became an even more complex, fragmented array of separate programs, with many of the most needy persons seen as 'falling betwen the cracks'." A similar situation exists in South Africa. Fourth, a shrinking national welfare budget and a depressed economic climate for fundraising demand accountability and cost-effectiveness in service delivery.

The pressure created by these factors led to the emergence during the 1970s of case management in its present form in the US (Moxley, 1989; Rothman, 1991; Weil, Karls *et al.*, 1985). In essence, case management is a synthesis of co-ordination of direct service delivery to clients and between service-delivery systems. Roberts-De Gennaro (1987: 466) describes case management as follows: "The concept of case management combines the best ideas of direct practice with the best ideas of community practice on behalf of a particular at-risk population." According to Austin (1993) co-ordination is at the core of case management.

In the US in the 1980s, case management was mandated by federal legislation and became an integral part of ageing, mental health, HIV/AIDS and developmental disabilities programmes as well as in medical settings and the private sector, e.g. health-insurance companies incorporated it into many of their products. Austin (1993: 451) refers to this trend as the "... presence, or perhaps omnipresence, of case management in health and social service programs ..."

In the United Kingdom the transition from a state welfare model of service delivery to a mixed economy model heavily relied on the concept of case management to develop a community-care model (Huxley, 1993). Although the reform from supply-driven to needs-driven services incorporated the case management concept, it underwent what Huxley (1993: 366) calls a "... semantic and linguistic engineering of the term case management into care management ..."

In South Africa the same problems are faced as in other countries but there are also unique features to consider. Although the vast majority of chronically ill or impaired older persons are cared for at home, service delivery to white older persons is dominated by institutional care. Service delivery remains characterized by racial and cultural inequalities which need to be addressed to bring about an equitable and culturally-sensitive service-delivery system. The existing

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backlog in developing and rural communities and the projected needs of the growing number of older persons pose a major problem for society in general and for fiscal resources. At present approximately 60 % of the total social welfare budget is spent on the care and allowances of older persons. Care of older persons therefore needs to be made cost-effective. Policy on the care of older persons emphasizes community care with supportive informal and formal resources; case management is a means of co-ordinating community care for older persons.

The nature of case management

Although case management is widely accepted and implemented, there are varied views on its nature. Rothman (1991: 520) refers to the "amorphous character of case management." It is therefore necessary to scrutinize some definitions of case management.

Weil *et al.* (1985: 2) give the following definition: "... case management is a set of logical steps and a process of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient and cost-effective manner."

The definition given by Moxley (1989: 11) is more comprehensive: "... case management can be defined as a client-level strategy for promoting the coordination of human services, opportunities or benefits. The major outcomes of case management are: (1) The integration of services across a cluster of organizations; and (2) achieving continuity of care."

Rothman (1991: 520) states: "Case management incorporates two broad functions: (1) providing individualized advice, counselling and therapy to clients in the community and (2) linking clients to needed services and supports in community agencies and informal helping networks."

According to Austin (1993: 451) American federal legislation defines case management very loosely, as "the coordination of a specified group of services for a specified group of individuals."

From these definitions the dual nature of case management is apparent, i.e. (1) direct service delivery which is continuous, co-ordinated and based on planned intervention to ensure quality care to the client, and (2) the administrative structure, inter-organizational networks, and informal and formal resources within which case management takes place and which aims at accountability and cost-effective utilization of resources. Case management on a micro level is client-centred: focussed on the needs and strengths of the client; and accepts "the reciprocal transactions between the individual and the environment, including formal agency resources and informal helping networks" (Rothman, 1991: 521). On a macro level it is concerned with the service-delivery system – its effectiveness and cost containment. Huxley (1993: 367) argues that the British concept of case management over-emphasizes the macro level and thus equates case management with "managed care" which is the North American concept of budget limitation in health services.

From the above exposition it appears that different terminology emphasizes different aspects of case management. "Managed care" refers to the co-ordination of a specified group of services for a specified group of individuals. An aim of co-ordination is cost containment through accountability and cost-effective utilization of resources. Clients' strengths, coping abilities and self-determination as well as informal helping networks are often overlooked in this interpretation. In this article the term "case management" is used to include its dual nature: on the micro level it is client-centred and takes cognizance of a client's needs, environment and informal networks; on the macro level it is concerned with the service-delivery system and its monitoring.

Practice models of case management

The variety of definitions and the wide adoption of case management by numerous human service-delivery systems imply that the service tasks and functions performed by workers could vary from setting to setting. Lauber (1992) examined the literature on case management and identified 13 case management tasks. In different settings certain of the tasks are grouped together to form a practice model. Such a practice model describes the case management process, i.e. the sequential steps to be followed.

The models of case management are spread over a continuum varying from a minimal model, through a co-ordination model to a comprehensive model (Korr & Cloninger, 1991: 131). Rothman (1991, 1994a,b) compiled a case management model which is based on the typical common functions performed in case management service and on the interrelations among these functions. This model, which he presented to South Africans at a conference on case management held at the University of Stellenbosch in 1994 (Rothman, 1994a), is used in the discussion below. (See Figure 1.)

Applying the case management components to aged care

Case management is particularly appropriate in service delivery to older persons. The reasons for this are: Their problems/needs are long-term; the problems/needs are multiple and often progressive in extent and intensity; and a variety of service options, often multi-professional, are required either supplementary to each other or in succession, to meet the needs of older persons. The various case management components are discussed against this background.

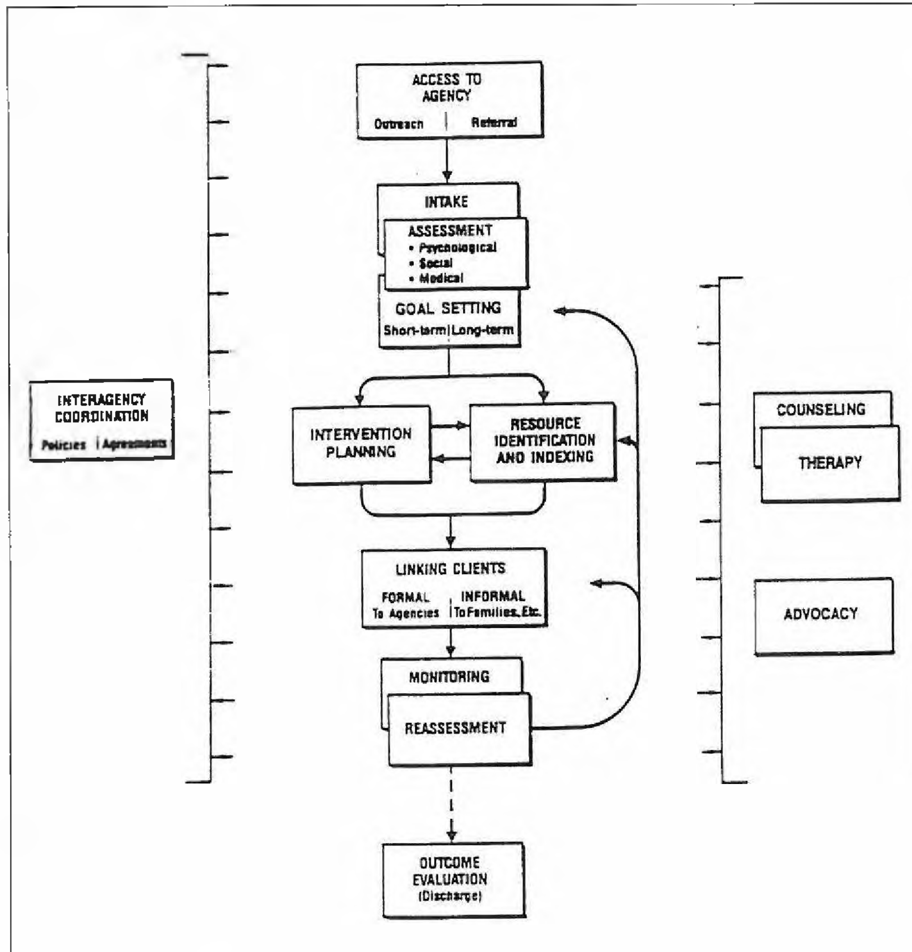
Assessment

Access to an agency is through referral – self, family, friends or other professionals – or outreach by the agency. Aged care requires pro-active action, i.e. intervention should occur with the first sign of dysfunction in order to prevent progressive dysfunctioning. It is therefore important that deliberate outreach should take place and that a tracing network should exist. The health professions play a very important role in such a tracing network. The hospital is a crucial tracing agent. Wimberley and Blazyk (1989: 270) argue "... the hospital is a natural funnel for identifying and following up on the high-risk, vulnerable elderly who are at risk of deteriorating functional status and premature institutionalization."

Assessment requires complete and verified facts to give a complete holistic picture of the older person, i.e. the person-in-situation perspective. This person-environment configuration is especially important with the aged. Changes in either the person or the environment can easily lead to malfunctioning. Hooyman and Kiyak (1991: 336) emphasize this aspect when they state: "... the older person's ability to control his or her surroundings ... is considerably reduced. The individual's range of adaptive behaviors to a stressful environment becomes constrained because of changes in physical, social and psychological functioning." Not only the person-in-situation should be understood but also the social networks which evolve from the reciprocal transactions between the person and the environment. This social network forms the basis of the older person's informal and formal support systems.

Moore (1990: 446) states that the following aspects should be assessed: The individual's ability to meet environmental

Figure 1
Schematic model of case management intervention



Source: Rothman, 1991: 523.
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challenges; the caring capability of the individual's family, the primary group and other informal resources; and the resources within the formal system of care.

The assessment process requires participation, and the British White Paper on care management (Hughes, 1993: 345) sets the following principles in this regard: (1) The assessment should be comprehensive and needs-driven, and should take into account what the individual can do to help himself; what informal care is available; particular risk factors; his/her abilities, life-style, health and accommodation; and social support needs; (2) the assessment should be multidisciplinary; (3) users and carers should participate in the assessment process; and (4) the assessment should play a key role in the overall evaluation of service provision and in planning for future development.

Not every referral will require a comprehensive assessment. An important function of case management is to determine eligibility. According to Weil *et al.* (1985: 13) case managers must also serve a gatekeeping function and "... they must scrupulously screen in those who need services and must carefully determine eligibility and screen out people who do not fit within the target population or whose service needs are not congruent with the capabilities of the service network." This is in accordance with the case management task of monitoring service-delivery systems to contain costs and thereby reducing overall spending (a managed care principle). A comprehensive assessment is indicated in all cases where fiscal spending is involved.

Good comprehensive assessment requires models of needs-assessment instruments. There is a dearth of such models internationally (Hughes, 1993); in South Africa there are no standardized models and agencies develop their own instruments. (The best known assessment instrument is the Older Americans Resources and Services (OARS) which covers five functional areas, i.e. physical health, mental health, activities of daily living, social resources and economic resources (Fillenbaum & Smyer, 1981).) Social network assessment instruments include an eco-map (Hartman, 1978; Hughes, 1993; Moxley, 1989; Ingersoll-Dayton & Arndt, 1990) and a social network analysis (Tracy & Whittaker, 1990). In the present restructuring of service-delivery systems in South Africa there is a need for multidisciplinary research to develop standardized measurement instruments for assessment of groups of older persons.

Planning services and identifying resources

Building on the assessment, the case manager and the client jointly decide what the desirable outcome of the intervention should be. This step is known as goal setting. Goal setting should be realistic and take into account limitations in the client, in the environment, in the available resources and in the service-delivery system. Goals are long-term and short-term, e.g. to reduce hospitalization, to enhance the level of social functioning, to keep a situation stable, or to relieve acute symptoms, crisis intervention or to meet housing needs.

The goals are then operationalized into specific tasks to carry out the intervention plan. Resources are identified in the client's informal support system: internal to the service-delivery system, or external in other service-delivery systems. Case managers need to know what resources are available in the resource pool, what the eligibility and service criteria are, and what their liaison and communication requirements are (Rothman, 1991; Rubin, 1987).

Linking clients and resources

This linkage is more than the referral of clients. Rothman (1991: 524) states: "The formal linkage function includes such activities as clarifying the service need, matching the client carefully, making the initial telephone contact, orienting the client, preparing papers, visiting agencies, and so forth." It therefore implies that the case manager should do everything that is necessary to get the client to the resource (Weil *et al.*, 1985). Resistance and limitation in the resource should be overcome, and this often requires advocacy by the case manager (Rubin, 1987).

The linkage function is difficult in South Africa where there is a disparate distribution of resources between the developed and the developing sectors, and also between urban and rural areas. Under these circumstances the case manager often has to be innovative and substitute informal resources for formal resources, e.g. establish a care group which can render services to other older persons. This would be more cost-effective than formal resources and could also supplement the income of the caregiver.

Implementation and co-ordination of services

Moxley (1989: 35) holds the following view of co-ordination: "For case management purposes, coordination involves seeing that the service plan is carried out and that the agency interactions and service delivery benefit the client and are in accordance with service agreements." Co-ordination thus takes place on the client level, i.e. to link the needs of the client to resources that can fulfil these needs to enhance the functioning and wellbeing of older persons, and on the service-delivery level, i.e. to get organizations to co-operate to advance a joint goal of service effectiveness. Co-ordination depends on good communication between the various service-delivery systems and good administrative practice, e.g. referral procedures and record keeping.

Monitoring service delivery

The case manager has to monitor the service-delivery programme, because he/she is often the constant presence in the fragmented service delivery to the client. The aim of monitoring is to see that the client receives the required services and that these services are necessary and relevant (Weil *et al.*, 1985).

Howes (1992) designed a monitoring instrument for case management (see Figure 2). This instrument contains all the functions of case management and can be used to monitor services to the client as well as the service-delivery system. The instrument makes it possible to obtain "organized data," i.e. "... systematic aggregations of information on the operations, costs and outcomes of such programs and systematic measurement of events in individual cases." (Reid, 1974: 585).

The instrument was specifically developed for a large senior centre under the auspices of a family welfare agency (the Bellville Senior Centre run by the Christelike Maatskaplike Raad (Christian Social Council)). The senior centre designed a computer programme for the instrument and the programme has been implemented for the past year. The instrument will be evaluated during 1995. Both functions of case management are incorporated in the instrument, i.e. it provides for an holistic picture of an older client and needs-driven services to the client, as well as a profile of the service-delivery system. The instrument enables the agency to monitor the cost of services and thus plays an important role in cost containment (the principle of managed care). It is also useful for planning services, e.g. to see where a demand for services is increasing and which services are under-utilized.

Figure 2
Monitoring instrument for case management of older clients

CASE MANAGER:

File No: ...... Ref. no.: ......

Name : ....
Adress: ....
....

Assessment:

Physical/ Psycho	totally independent	needs assistance	needs support
	needs supplementary service	needs constant care	totally bed bound

Social	Single	Couple	
	independent living	sheltered housing	living with children
	living with others	boarder	

Econ.	Grant. O.A.P.	Sub-econ.	Econ.
	Home owner	Tenant	

REMARKS

SERVICE PLANNING: Receives (date)	SERVICE PLANNING: Needs (date)	SERVICES	REFERRAL: Referred by	REFERRAL: Referrred Internal	REFERRAL: Referred External	SERVICE UTILIZATION Month: 1	2	3	4	5	6	7	8	9	10	11	12
		a) Senior Centre															
		Meals															
		Clinic															
		Podiatry															
		Hair salon															
		Social															
		Recreation															
		Educational															
		b) Material assistance															
		i. shop															
		ii. clothing															
		iii. linen															
		c) Home care															
		Meals															
		Home help															
		Garden service															
		Home care															
		Nursing															
		Transport															
		Visiting															
		Laund ry															
		d) Professional services															
		Consultation															
		Crisis Intervention															
		Stroke Club															
		Alz/Dem group															
		Depression Group															
		Bereavement Group															
		Support system															
		Maintenance															
		Carer support															
		e) Other:															

Evaluation and re-assessment

Evaluation is an ongoing process. What is evaluated? First, whether the intervention process is moving towards the planned goal, and second, whether the time schedules set in service planning are being adhered to. Rothman (1991) points out that a final outcome evaluation is never possible because of the continuing care situation.

The long-term continuing care context in which case management occurs requires re-assessment at regular, scheduled intervals. Rapid change or deterioration as well as a crisis situation will require re-assessment.

Who acts as a case manager?

According to Douville (1993: 44) the social work profession holds a strong claim on case management in both mission and training, and social work's person-in-environment paradigm. Although social workers have the knowledge and skill base to perform case management functions, case managers are trained in a variety of disciplines and use a number of case management models in various fields of service. Merrill (cited in Kaplan, 1990: 64) divides these models of case management on the basis of category of client served and the types of services co-ordinated, e.g. social case management, primary-care case management, and medical/social case management. Social case management is based on a co-ordination of the necessary social services and resources to maintain the old-old in their homes and communities and to avoid permanent institutionalization. Primary-care case management is where a case manager, frequently a physician, provides a patient's primary care and authorizes and co-ordinates other health-care services deemed necessary for the patient. The medical/social model of case management focusses on specific populations, where members have already experienced a significant health problem, have been institutionalized at some point because of the problem, and are at risk of needing further costly institutionalization. Programmes based on this model offer both medical and social services aimed at keeping clients out of an institution for as long as possible.

In caring for older clients the needs of the target population are usually complex and the service system invariably fragmented and with limited resources. Research in the US (Kaplan, 1990: 71) found that " ... social workers are the professionals of choice for case management when psychiatric cases are involved or when it is necessary to marshal a large pool of community resources." Although case management was developed and tested in societies with a well resourced network of services, it should also be available in poorly resourced areas. In such a case it would require that the case manager develop informal networks and resources to perform the tasks of formal resources. Social workers have the knowledge and skills to accomplish this task.

Another aspect of the task of the case manager is the degree of involvement of the client and the family. Does the case manager only co-ordinate the service delivery to the client, or does he/she also provide direct services to the client, e.g. counselling? Douville (1993: 45) points out that virtually all programmes researched or reviewed in the literature are model programmes in which case management itself is the primary service. If a comprehensive model of case management, as suggested in Figure 1, is applied, it would follow that the case manager's main task is intervention planning, linking clients and monitoring service delivery. According to Rothman (1991: 524) research indicates that monitoring requires a definite and substantive allotment of time, and time should be available to deal with crisis situations that are bound to arise. The case manager is at the interface between direct service delivery and the service-delivery system. The case manager is thus more of an administrator and a broker than a practitioner (Cnaan, 1994: 533).

Conclusion

Rendering effective services to older clients requires assessing their needs, linking the client to resources, and monitoring the service-delivery system. Case management offers a viable means of achieving this aim. Case management makes it possible to co-ordinate services at the client level and thus aims at rendering quality care to the client and co-ordinating services on intra-organizational and inter-organizational levels, thus containing the cost of service delivery.

Case management is not a panacea for the problems of service delivery to the aged. Although case management is mandatory in both the US and Britain, Cnaan (1994) warns against a trend to copy what is currently popular without examining its usefulness in a specific cultural and economic context.

As South Africa is now in the process of replanning and restructuring its service-delivery system, the usefulness of case management to co-ordinate community care of older persons should be considered. Political, economic and social factors require that care providers consider new ways to render effective services while simultaneously containing costs. Case management models may be tested in hospital settings to co-ordinate services to older persons following discharge in order to avoid rehospitalization, and with community-dwelling older persons who require supplementary services to avoid institutionalization. It is only in this way that the benefits and drawbacks of case management programmes in South Africa may be determined and indigenous models developed.

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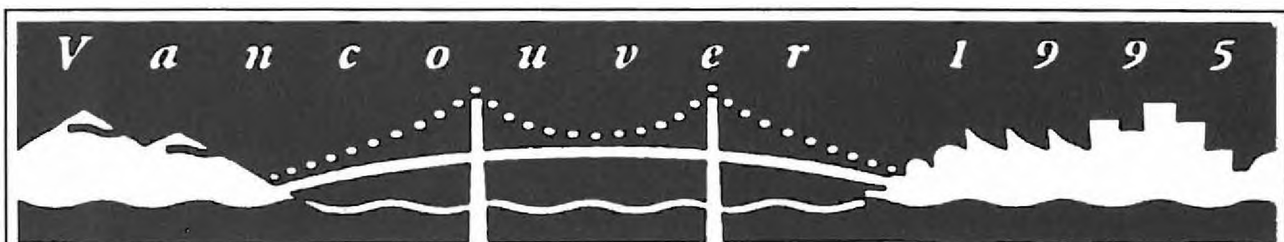

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