

Social Work Best Practice Healthcare Case Management Standards

Introduction

Currently, the term Case Management has varied meanings within the context of its use by multiple professions. Consequently, these variations and the lack of nationally supported standards create inconsistent understandings related to Social Workers practicing Case Management.

The result is the inconsistent application of Social Work in Healthcare Case Management. Case Management Social Work practice now varies from no involvement to task oriented discharge planning to complex patient care and family planning/intervention. Our patients and families receive varied degrees of benefit from Social Workers in Case Management. Finally, the Healthcare Industry needs to commit to the application of Social Work in Case Management and use national standards to define their application.

The Social Work Best Practice Case Management Standards document was developed by a consortium of professional organizations which represent Social Workers. These standards are intended to assist Social Workers in their practice of Case Management.

Definition

Social Work Case Management is a method of providing services whereby a professional Social Worker collaboratively assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs. The practice of Case Management varies greatly across Social Work settings and is even more diverse as applied by other professionals. Despite this diversity, several elements distinguish Social Work Case Management from other forms of Case Management. A professional Social Worker is the primary provider of Social Work Case Management. Distinct from other forms of Case Management, Social Work Case Management addresses both the individual client's biopsychosocial status as well as the state of the social system in which Case Management is both micro and macro in nature: intervention occurs at both the client (patient and family) and system levels. It requires the Social Worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide him or her with needed services, resources, and opportunities. Services provided under the rubric of Social Work Case Management practice may be located in a single agency or may be spread across numerous agencies or organizations.

Case Management is sometimes confused with managed care, a term generally associated with direct cost containment measures because some (insurance) carriers use "Case Management" and "managed care" interchangeably, or use yet other terms for similar strategies. However, the two concepts are quite different. Managed care techniques are designed to avoid hospitalization when possible and to shorten unavoidable hospital stays – to reduce costs by discouraging the unnecessary use of medical services.

The intent of Case Management is not to avoid medical care. On the contrary, it is designed to obtain the best and most appropriate treatment for patients whose need for care is beyond question. Instead of discouraging consumption of medical or social services, it encourages the most effective use of health care or social services and dollars.

Education & Training

Social Work Case Management requires formal education, professional work experience, and professional credentialing. The social work case manager shall:

1. Be a graduate from a Masters program accredited by the Council on Social Work Education.
2. Maintain current professional state social work licensure/certification or national social work certification.
3. Complete two (2) years of master's level work experience related to the bio-psycho-social needs of the served population.
4. Practice in accordance with applicable state and federal regulations, statutes, and laws.
5. Adhere to NASW Social Work Code of Ethics.

Social Work/Scope of Services for Case Management

Case Management has both Clinical and Psychosocial components. With the appropriate education and training, a Social Work Professional can collaboratively address many requisite functions. Among these are the following:

Psychosocial Assessment & Diagnoses/Planning/Intervention
Financial Assessment/Planning/Intervention
Case Facilitation
Patient and Family Counseling
Crisis Intervention
Quality Improvement
Resource Brokering/Referral/Development
Discharge Planning
System Integration
Outcome/Practice Evaluation
Teamwork/Collaboration
Patient/Family Education
Patient/Family Advocacy

The Social Worker works collaboratively with other professionals to maintain a team-oriented approach to Case Management. This approach also incorporates the patient and family in care decision making.

Quality of Care Indication

Screening

The type of Case Management offered by the organization is the key to the screening criteria selected for use. All criteria should be developed for the overall purpose of coordination of quality health care services, reduction of service fragmentation, enhancement of quality of life, and the appropriate use of health care resources. Screening criteria are often aimed at the identification of patient's with the following types of "high risk":

- Those with catastrophic conditions
- Those with costly injury/illness
- Those who are non-compliant/non-adherent in following treatment plans
- Those in the acute phase of chronic illness
- Those in the terminal phase of illness

All screening should include a situational analysis of the patient. Additionally, a functional screening of the patient must be conducted and include the following elements:

- Physical
- Psychosocial
- Financial
- Environmental
- Cultural/spiritual
- Vocational
- Learning potential
- Community reintegration potential

Assessment

The psychosocial assessment forms the basis for the Social Work Case Management process and includes the following components:

1. Personal Data
2. Health Status/Age
 - a. Disease Process
3. Advanced Directives Status
4. Emotional Status
5. Cognitive Functioning
 - a. Learning Ability
6. Functional Status
 - a. Spirituality
7. Cultural Issues
8. Patient Support System
9. Caregiver Support System
10. Financial Status
11. Vocational Status/Potential

12. Community Reintegration
13. Home & Community Environment

Reassessment is an ongoing process, with a formal reassessment conducted at prescribed intervals and whenever there is a significant change in the patient's health, abilities, living situation, family involvement, etc. Reassessment should include evaluation of the type and intensity of case management services required, with changes made to the treatment plan accordingly.

Intervention Methods/Options

Development of Social Work Case Management Treatment Plan – Once several options have been developed, the Social Work Case Manager helps patients and family members/significant others review advantages and disadvantages to each option. Together, the Social Work Case Manager, patient, and family/significant others formulate an individualized effective case management treatment plan and implementation strategies. The plan will identify the patient's strengths and support systems and utilize them in implementation strategies.

Collaboration – The Social Work Case Manager will collaborate with patients, family members/significant others and interdisciplinary team members on implementation of the plan and will keep team members informed about progress toward goals, obstacles, and changes to the plan.

Continuum of Care – Case Management is provided across the continuum of care. Social Work Case Managers regularly follow patients from community to inpatient to ambulatory to community settings and adapt the case management treatment plan as the patient's needs change. Reevaluation, planning, and referrals as appropriate are required to ensure Continuity of Care.

Documentation

Case Management Plans of care are developed and documented in the patient's medical record and are located strategically for access and notice by all relevant and authorized health professionals involved in a patient's care.

Social Work Case Managers will document the patient's understanding and acceptance of the Case Management plan developed.

Social Work Case Manager documentation focuses on new and pertinent information relevant to the current/proposed course of treatment or future planning.

Social Work Case Management and all Medical Record Documentation is confidential in nature and should be treated accordingly.

Social Work Case Management Documentation is to be signed by the Case Manager with the individual's specific professional credentials identified (MSW, ACSW, etc.).

Quality of Care Indication (Outcomes)

Measurement of Outcomes – For each problem, issue, or concern identified, the Case Management treatment plan will have observable and measurable goals for each problem, issue or concern identified and expected outcomes. Progress toward goals will be periodically measured by the social work case manager in collaboration with the patient, family member/significant others and team members. Based on the outcomes and progress, changes will be made to the plan as needed. Outcomes measurements should include the following:

Problem Resolution

1. Identified individual patient care plan goals met (% met, % not met, % partially met)
2. Patient adherence to treatment as measured by:
 - a. Increase in attendance at planned treatment sessions (i.e. dialysis treatments, doctor's appointments, etc.) or
 - b. Decrease in unplanned treatments or procedures (i.e. ER visits)
3. Change in health status – measured by clinical laboratory values or other physiological testing (i.e. cardiac stress test, pulmonary function test, etc.)
4. Change in Patient functional status/degree of disability
5. Change in patient behavior- increase in self-management activities

Utilization Management

1. Cost of services provided (when available)
2. Utilization of resources as measured by length of hospital stay, hospital readmissions, ER visits, home health visits, etc.
3. Appropriateness of level of service (were patient needs matched with appropriate provider services)

Client Satisfaction

1. Patient satisfaction questionnaires
2. Patient-perceived quality of life (measured by questionnaire like SF-36, DUKE Health Profile or Dartmouth Co-op)
3. Client contract renewals (i.e. HMO or insurance company satisfaction)

This document was written by a coalition of Social Work organizations/associations. Its intent is to describe Best Practice.

BIBLIOGRAPHY

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