



CASE MANAGEMENT AND COMMUNITY CARE

A DISCUSSION PAPER

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EXECUTIVE SUMMARY

Frail older people, people with disabilities and people with chronic health conditions face many challenges in living as independently as possible in their own homes and communities. Often their needs are complex, the services which can meet them are often hard to find and they have difficulty managing without assistance. Complex needs can be either ongoing or short-term based on health conditions or their living situation. Case Management provides a framework to coordinate and provide health and social services for people with complex care needs. This paper focuses on community based case management.

Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health¹ needs through communication and available resources to promote quality cost-effective outcomes.²

Case Management involves working across many boundaries, with healthcare and various systems that interlink in many ways throughout a person's life. Case Managers understand how each system interacts with the other and the importance of getting that interaction right.

Case Management ensures a match between the available resources and client needs, making the best use of what is available. This benefits the individual client as it provides appropriate services and supports, as well as the system as a whole by reducing client dependence on funded supports and maximising independence where possible.

Case Managers unravel dilemmas relating to any area of life that clients find they need assistance in, and address issues which other people take for granted as being able to solve with little consideration. When case management is expertly performed the complexity of the process often goes unnoticed by others.

The community care system is in a period of review and reform. The Australian Government has released a paper *The Way Forward* which sets broad directions for the reform process and this provides an opportunity for case management and its role to be actively and appropriately considered. Aged & Community Services Australia (ACSA) and the Case Management Society of Australia (CMSA) have recognised the need for a policy direction for case management in relation to the community care service system. This paper:

- describes case management and its role in community care;
- articulates the distinctive features of case management; and
- demonstrates the benefits and outcomes case management can deliver for individual clients, their natural networks and the community care system as a whole.

The working group has identified other issues that are not the focus of this paper but should be considered in future discussion including ethical practice, workforce planning, funding models, funding for case management evidence-based research, education, practice management and accreditation of organisations practising case management.

Case management is an important service which should be available throughout the community care system to support people with complex care needs. It is important that the current reform agenda for community care acknowledge and support the role of case management in each of the three proposed community care tiers. This will be one way of ensuring that there is optimal use of the limited available resources and that community care is a viable alternative to more costly forms of care.

¹ The World Health Organisation definition of health is a state of complete physical, mental and social well-being, not just the absence of disease or infirmity. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946. Signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

² CMSA *National Standards of Practice for Case Management*, 2004.

INTRODUCTION

Frail older people, people with disabilities and people with chronic health conditions face many challenges in living as independently as possible in their own homes and communities. Often their needs are complex, the services which can meet them are often hard to find and they have difficulty managing without assistance. Complex needs can be either ongoing or short-term based on health conditions or their living situation.

Case Management provides a framework to coordinate and provide health and social services for people with complex care needs. Case Managers provide a single point of contact for clients who require a complex range of services and/or require intensive levels of support on either an ongoing, short term or episodic basis. Case management services focus on maximising the individual's capacity for independent living in the environment of their choice and serve to inform service system developments that better meet client needs.

The beginnings of the case management model can be traced back to the 1970s but it rose to prominence, particularly in Australia, during the late 1980's and early 1990s with the growth of provision of care to frail older people and young people in the home and community. This coincided with moves by governments to deinstitutionalise care and maintain people within their families and community for the longest possible time. Case management has been utilised in many areas of the health and social service system in the acute, community and home care settings.

Case management is a component of a number of growing community care funding programs such as Community Options³ through the Home & Community Care (HACC) Program, Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) Packages. Case management has a role in the service system discrete from particular funding programs in that it assists an individual client access multiple services/programs and alternative resources including informal supports. Policy and program development to date has not fully considered this potential.

The community care system is in a period of review and reform. The Australian Government has released a paper *The Way Forward* which sets broad directions for the reform process and this provides an opportunity for case management and its role to be actively and appropriately considered.

Aged & Community Services Australia (ACSA) and the Case Management Society of Australia (CMSA) have recognised the need for a policy direction for case management in relation to the community care service system. A working party has been formed to develop this.

ACSA is the leading national peak body for aged and community care providers and represents over 1,200 church, charitable and community-based organisations providing housing and supported accommodation, residential and community care services to around half a million older people, younger people with a disability and their carers.

CMSA is the peak national body for Australian Case Managers. The society aims to promote the developing profession and the viability of the service model in coordinating care and resources for clients with complex needs. The society has successfully attracted members from a range of sectors including aged care, disability, mental health, correctional services, child protection, injury management, employment services, insurance and disease management areas among others.

³ Known as Linkages in Victoria.

The Purpose of this Paper

This paper focuses on community based case management and aims to:

- describe case management and its role in community care;
- articulate the distinctive features of case management; and
- demonstrate the benefits and outcomes case management can deliver for individual clients, their natural networks and the community care system as a whole.

There are other discussion papers which examine the role and outcomes of case management, from particular vantage points. This paper has been developed by case management practitioners and organisations that provide services, including case management, to people who require assistance.

In developing this paper ACSA and the CMSA intend to clarify the role of case management in community care. This will provide a valuable contribution to the effective reform of the community care system.

CASE MANAGEMENT

There are various definitions of case management and, as with any service model, people use different terms to describe it. This paper uses the definition developed by the CMSA.

*Case Management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.*⁴

The term health is used here, and throughout this paper, in its broadest sense based on the World Health Organisation which states that health is a state of complete physical, mental and social well-being, not just the absence of disease or infirmity.

Case Managers provide a single point of contact for clients who require a complex range of services and/or require intensive levels of support on either an ongoing, short-term or episodic basis. They work with, and for the individual, enhancing independence and control.

Principles

Case Managers work within a number of principles⁵ which reflect the philosophy behind case management:

A single point of contact – the relationship with the Case Manager is the foundation on which the case management process is based, working in partnership with the individual and their family or carer. Case Managers are also a single point of contact for other service providers. This does not limit communication by making the Case Manager the only point of contact.

Life strengths approach – acknowledges that every individual has strengths that should be the focus of the interaction between the Case Manager and the client. This approach maximises the physical, social and psychological well being of the individual to achieve their optimal level of independence and assist in their participation in the community commensurate with their capacity and choice. **Case management facilitates the personal development of clients.**

Collaboration – Case Managers work collaboratively with other service providers and professionals involved with a client to ensure the best possible outcomes for that person.

Individualised – client focussed support ensures each person receives the appropriate level and type of support according to their needs, culture and budget constraints, working towards jointly agreed goals.

Continuity of care – clients have a right to expect continuity of service across time and service boundaries in order to meet individual needs.

Flexibility – support can be delivered in a way that suits individuals' needs and varied according to the changing needs of the individual.

Boundary - spanning – Case Managers draw upon all available resources, both formal and informal to provide support in the most cost effective manner.

Culturally appropriate – ensuring diversity is respected and catered for.

Creative – Case Managers work “outside the square” to find innovative ways to meet needs.

⁴ CMSA *National Standards of Practice for Case Management*, 2004.

⁵ Based on “*What is Community Care Case Management?*” National Community Care Case Management Network, 2005.

Empowerment – clients are supported, through the provision of information, to manage their own affairs as far as possible.

Confidentiality – is maintained at all times in accordance with legislative requirements and program standards.

Case Management Functions

Operating within these principles Case Managers undertake the following functions⁶:

Comprehensive needs assessment – in collaboration with the client and their families/carers, identify personal needs and function levels to maintain quality of life in the community. This assessment is an ongoing process and draws in specialist expertise, such as a Geriatrician or Occupational Therapist, as required.

Care and service planning – a care plan is developed in consultation with client nominating short and long-term goals, incorporating family and carer needs, and defining the service responses required.

Resourcing the care and service plan – the care plan is resourced in a variety of ways including:

- the use of brokerage funds to purchase services and support (including equipment) to meet an individual's needs;
- provision of services from relevant programs;
- support provided by carers, such as family members or friends;
- client fees and contributions; and
- seeking funding from alternative sources, such as Lions Club or Rotary or other government funding when available.

Case Managers ensure the resources used are safe, efficient and effective.

Navigation – Case Managers know the various services and supports available for people. They determine what is needed in consultation with the client and carers and how to utilise and maximise what is available for an individual.

Implementation – fostering community supports and linking with and commencing services where required in a timely fashion.

Monitoring – ensuring the client is receiving the level and quality of service provision that best meets their needs.

Advocacy – support the client in appropriating services that meet individual needs and goals, support and educate the individual to develop self-reliance in self-advocacy. Case Managers advocate on behalf of clients but clients are encouraged and empowered to advocate on their own behalf.

Evaluation – ensure services provided are meeting the needs of the clients and carers and are cost effective to the service system. Where this is no longer the case alternative arrangements are made.

Closure – when case management is no longer required discuss with client and carer, inform services, develop a transfer plan and then withdraw.

⁶ Based on “*What is Community Care Case Management?* National Community Care Case Management Network, 2005.

DISTINCTION OF CASE MANAGEMENT FROM OTHER SERVICE MODELS

A range of service models have emerged in the Australian health and social service system, all with their own political origins, motives and life spans, which are sometimes referred to as case management. These models focus predominantly on care coordination but often have a particular dominance within a particular service sector (eg acute health). Case co-ordination sees a co-ordinator managing the different services required/provided to support an individual at home. Table 1 outlines a sample of various service models and their focus.

Case management is different to these models as it focuses on the full range of health and social care needs of individuals with complex care needs.

In some models case management is separated from the direct service provision role while in other models the two are combined. In small rural communities the combination of case management and service provision is the only realistic and viable approach.

Case management involves working across many boundaries; with healthcare and various systems that interlink. Case Managers understand how each system interacts with the other and the importance of getting that interaction right.

Case Managers support clients in any area of life they find they need assistance in and address issues which other people take for granted as being able to solve with little consideration. This is done by assisting individuals to access the support they need. When case management is expertly performed the complexity of the process often goes unnoticed by others.

It is the complexity of the individual's care need and the response provided that defines and distinguishes case management from the other models which essentially focus on single need care co-ordination.

Table 1: Service Models

Service Model	Primary Focus
Community Case Management	The full range of community and health care needs of individuals with complex care needs.
Disease Management	Co-ordination of clinical pathways and pharmacological needs of individuals with diagnosed diseases, conditions or illnesses.
Hospital Demand Management	Co-ordination of services which reduce the need for admission or re-admission to hospital.
Self Care Management	Empowering clients by skill development to care for themselves.
Wellness Management	Health promotion as opposed to 'sickness' and attempts to minimise health and social risk, preferably before the onset of any issues.
Population Health Management	An established population group and the range of needs within that defined population.

CASE MANAGEMENT IN PRACTICE – A CASE STUDY

Audrey⁷ is a 78 year old pensioner who lives alone in rural Victoria. Audrey has two daughters – one lives interstate and the other one lives overseas. Audrey has osteoarthritis, rheumatoid arthritis, cardiac problems, and glaucoma. Audrey suffers from insomnia, anxiety and depression. Six months ago she fractured her hip and experiences chronic and ongoing pain as a result.

Given Audrey's complex medical conditions she has many medical appointments. Audrey has been missing appointments because she is unable to access public transport and the cost of alternative transport services. Her telephone has recently been disconnected because she has not been able to pay the bills.

Audrey had been completely independent but since fracturing her hip she has lost her confidence and become overwhelmed and anxious in managing her day-to-day affairs.

Audrey's GP believes that she should be assessed for low residential care because he is concerned that she can no longer manage on her own. As the ACAT has a waiting list of one month the GP contacted the local Community Options (COPS) package service who after meeting Audrey agreed to provide a package in the interim. As a result of this Audrey was assigned a Case Manager. The Case Manager spent time getting to know Audrey and identifying the various issues which were making Audrey feel that she could no longer cope at home.

Audrey did not really want to go into residential care but felt she had no alternative. The Case Manager believed that with some limited services and increased confidence Audrey would be able to continue to live independently. Armed with Audrey's preferences and her own knowledge of resources available the Case Manager:

- organised for a home cleaning service to be provided fortnightly;
- introduced the idea of supported/assisted living;
- assisted Audrey to find an independent living unit in the closest regional city which catered for people on low incomes;
- assisted Audrey to obtain the correct advice to complete the relevant paperwork for the independent living unit;
- sourced an affordable relocation service, using the Salvation Army;
- arranged a financial counsellor to work with Audrey to develop a budget;
- advocated on Audrey's behalf with the phone company to address unpaid bills and re-connection costs; and
- organised an ongoing transport service through the Red Cross to ensure medical appointments were able to be kept.

Audrey has settled into her new home well and continues to receive assistance with her housework. The relationship developed with her Case Manager has given her confidence (which built gradually) in her ability to remain living in her own home. One of the benefits to Audrey is the fact that she knows she need only call one person if she has any difficulties managing her affairs. The Case Manager can point Audrey in an appropriate direction because of the knowledge of the service system and empower her with the confidence to navigate the system. Without this assistance it is likely that Audrey would have gone into residential care.

Initially the Case Manager spent 10 - 12 hours per week (on average) supporting Audrey. Once the move occurred and Audrey was settled this decreased significantly. The Case Manager continues to provide a contact point for Audrey and monitor whether other services and support are needed. Minimal ongoing monitoring ensures Audrey's confidence is maintained and reduces the likelihood of another crisis situation developing that could lead Audrey to residential care.

⁷Audrey is a composite of real life cases.

CASE MANAGEMENT OUTCOMES AND BENEFITS

Case management is at its most effective when a client experiences one, or most likely a combination of the following factors⁸:

- Limitations in cognitive, perceptual or social functioning
- Behavioural, emotional or mental health issues
- Lack of informal support network, or carers who need support
- Social or geographic isolation
- Level of physical frailty or vulnerability impacting on the ability to organise their own care or advocate on their own behalf
- Involvement of multiple services
- Coming from diverse cultural or linguistic backgrounds
- At high risk of inappropriate institutionalisation

ACSA and the CMSA maintain that when case management is used appropriately – to support people with complex care needs – it delivers tangible benefits to individuals and to the system as a whole.

The main benefits are:

Clients are Supported to Access the System

Case management provides a single point of contact for the client, carer and other service providers. The Case Manager navigates the system with the client and carer and through this provides extra support for families. One of the driving forces behind the current Australian Government reform agenda is to make the system easier to navigate for consumers and carers. While the reform agenda will streamline aspects of the community care system, people with complex care needs will continue to need help to access the supports they require.

Optimal Use of Available Resources

Case management identifies the most appropriate type and level of service and/or support. It organises a tailored package of care to meet an individual's specific needs and then monitors to ensure the services are delivered. This results in better utilisation of available resources through better co-ordination of services. Given the increasing demands being placed on community care it is important for the system to have methods which ensure a match between a client's needs and the services available. Case management is one such way that this can be achieved.

Supporting Independence and Providing Confidence

Most people express a desire to remain living in their own home and community for as long as possible. One of the main factors in people moving from home to residential care is a lack of confidence and security. Confidence is needed in the physical ability to manage at home as well as the psycho-social ability.

Case management provides a package of care plus the security of having one person you can contact if you have any difficulty. This combination provides a sense of security that you can stay at home and be adequately supported.

⁸ National Community Care Case Management Network, "What is Community Care Case Management? 2005.

An Alternative to Residential Care

The available literature shows that intensive, case managed community services provide alternatives to entry to residential care.⁹ One of the major aims of many community care programs is to reduce or delay inappropriate admission to residential care alternatives. Case management then is one way to assist in achieving the aims of community care generally.

Service Innovation

Because case management works to tailor what is available to meet specific client needs and can venture outside the realm of what is generally available in community care it is often a driver for service innovation.

Reduced Use of Health Services

A recent evaluation of the New South Wales ComPacks program¹⁰ showed that of the people who stayed in hospital more than 21 days, those referred to ComPacks stayed on average 8.9 days less than people not referred for ComPacks.¹¹ ComPacks is delivered for \$30 per day compared with \$350 per day for inpatient sub-acute care.

This demonstrates that case management can reduce the use of health services and is substantially more cost effective.

There are programs similar to ComPacks in most other States.

⁹ Yvonne Wells, Hal Swerissen, and Hal Kendig, "Client Outcomes in Case Managed Care: Who Benefits Most?" *Australasian Journal on Ageing*, 18 (2), 1999.

¹⁰ ComPacks is a joint discharge program between multidisciplinary health teams and community care Case Managers in the Community Options (COPS) program.

¹¹ NSW Health, *ComPacks Project Evaluation Report: Final Draft*, September 2004.

CONCLUSION

Case management is an important service which should be available throughout the community care system to support people with complex care needs.

Case management ensures a match between the available resources and client needs, making the best use of what is available. This benefits the individual client, as it provides appropriate services and supports, as well as the system as a whole by reducing client dependence on funded supports and maximising independence where possible.

Case management is able to do this because it takes a holistic approach to an individual, cuts across traditional funding and program boundaries and harnesses generic community resources and informal supports. This is different to many other models which purport to be case management but are really just ways of co-ordinating service delivery.

Case management is not duration specific but may be intense for a short-term or on an episodic basis or on an ongoing basis depending on the needs of the client.

Future work identified by the working group that requires discussion and direction include ethical practice, workforce planning, funding models, funding for case management evidence-based research, education, practice management and accreditation of organisations practising case management.

The community care reform agenda proposes that the system of care be based on three tiers:

- early intervention;
- HACC service delivery (or low/medium care needs); and
- packaged (or high/complex) care.

This paper has demonstrated – perhaps most clearly in Audrey’s case study – that complexity can be experienced by people who require relatively minimal levels of ongoing services. Complexity can not only be determined by the number and hours of service required. In an ongoing sense a person may need minimal service delivery but determining this and ensuring the most appropriate service is delivered is a complex task.

It is important that the current reform agenda for community care acknowledge and support the role of case management in each of the three proposed community care tiers. This will be one way of ensuring that there is optimal use of the limited available resources and that community care is a viable alternative to more costly forms of care.

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