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**Governor's Planning Council  
on Developmental Disabilities**

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CASE MANAGEMENT: AN INTEGRATED MODEL

prepared for:

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# TABLE OF CONTENTS

	<u>Page</u>
OVERVIEW.....	1
Contract Obligations.....	1
Report Outline.....	2
Rationale for an Integrated Model.....	2
TRENDS IN THE EVOLUTION OF CASE MANAGEMENT.....	4
Overview.....	4
Early (Pre 1960) Trends.....	5
The 1960's and 1970's.....	6
Federal Policy Development.....	8
President's Commission on Mental Retardation (1962).....	9
Developmental Disabilities Act (1975).....	9
National Institutes of Mental Health (Mid 1970's).....	10
Mental Health Systems Act (1980).....	10
Long-Term Care Demonstration Grants (1980)...	10
Minnesota Policy Development.....	11
Statutes and Rules.....	11
Status of Case Management in Minnesota.....	18
Definition of Case Management.....	19
Role of Case Manager.....	20
Population Specific Needs Identified....	21
Rural County Problems.....	22
Summary of Status of Case Management in Minnesota.....	23
Case Management: The 1980's.....	24
CASE MANAGEMENT: AN INTEGRATED MODEL.....	26
Overview.....	26
Model.....	26
Definition of Case Management.....	28
Components of the Case Management Process.....	29
Components Defined.....	29
Assessment.....	30
Role of the Case Manager in Assessment.....	31
Client Plan.....	31
Role of the Case Manager in Client Plan.....	32
Resource Allocation.....	33

Role of the Case Manager in Resource Allocation.....	33
Service Coordination.....	34
Role of the Case Manager in Service Coordination.....	34
Monitoring of Service Delivery.....	34
Role of the Case Manager in Monitoring of Service Delivery.....	35
Reassessment and Evaluation.....	35
Role of the Case Manager in Reassessment and Evaluation.....	36
Role of the Case Manager in Fiscal Responsibility and Cost Containment.....	36
ISSUES IN THE IMPLEMENTATION OF AN INTEGRATED CASE MANAGEMENT SYSTEM.....	39
Overview.....	39
Role of the Case Manager.....	39
Qualifications of the Case Manager.....	43
Preadmission Screening and Alternative Care Grants Program.....	44
Proposed Rule 185 for Mentally Retarded.....	45
Proposed Amendment to Chapter 2568.09 Establishing Pilot Programs With Local Screening Teams and Case Management Efforts for Mentally Ill Persons.....	45
Components of Case Management.....	47
Training for Case Management.....	48
Caseload Standards.....	49
Contracting Case Management Services.....	50
Integration of the Human Service Delivery System.....	50
RECOMMENDATIONS	
General.....	52
Role of the Case Manager.....	52
Qualifications of the Case Manager.....	53
Components of Case Management.....	53
Training.....	53
Caseload Standards.....	54
BIBLIOGRAPHY.....	55
APPENDIX A: INTERVIEWS.....	58
APPENDIX B: KEY PROVIDER REVIEWERS.....	60
APPENDIX C: LEVELS OF CASEMANAGEMENT DEVELOPED BY OLMSTED COUNTY DEPARTMENT OF SOCIAL SERVICES.....	62
Chemically Dependent.....	63
Mentally Ill.....	65
Mentally Retarded.....	67

## OVERVIEW

### Contract Obligations

The contract between the Department of Human Services and Health Planning & Management Resources, Inc. specified the following obligations:

1. Review and analyze existing literature related to case management.
2. Interview individuals from state, county, and public and private agencies regarding current status of case management in their systems.
3. Examine issues related to the functioning of the case management process including authority of the case manager, family role, authority and responsibility and current status of financing of case management
4. Develop an integrated case management model that can be used by county social service and health agencies in working with disabled adults, addressing special needs of various target populations.
5. Articulate the role of the case manager.
6. Make appropriate recommendations regarding the development of case management for the Department of Human Services.

This report summarizes the results of the investigations of the consultants and is presented in partial fulfillment of contract requirements.

Appendix A lists those persons who were interviewed as a part of this investigation. Appendix B identifies individuals who reviewed various stages of the model development and made appropriate suggestions.

This report and model, though incorporating many of the useful suggestions of the reviewers, does not represent the consensus of the reviewers.

### Report Outline

The following are presented in the remainder of this report:

1. Trends in the evolution of case management.
2. The integrated model
3. Issues in the development of case management.
4. Conclusions and recommendations.

A literature search was conducted, and the bibliography presented at the conclusion of this report identifies sources that were used most extensively by the authors.

### Rationale for an Integrated Model

The primary purpose expressed by the contractor for the development of the integrated model of case management was to

provide a workable model that could be applied to all adult target populations with minor modifications.

The majority of Minnesota counties have three or fewer adult service workers who must work with all five adult target populations. To have different case management models for each population would be unworkable at the local level.

## TRENDS IN THE EVOLUTION OF CASE MANAGEMENT

### Overview

The concept of case management as a process for assisting the multiple-need client access and use the human service system has existed since the late 19th century. Until recently, case management had focused nearly exclusively on the welfare of the client. Client welfare was equated principally with the client's ability to gain access to the system to secure services.

The heightened interest in case management in the early 1980's has been spurred principally by the hope that case management can serve as a cost containment measure.

This section of the report is based on the literature review and traces the evolution of case management in some detail, both nationally and in Minnesota. There are extensive resources available on case management in relationship to various target populations. The authors of this report have attempted to summarize the literature on case management in such a way that there is a context for the proposed integrated model of case management and the discussion of issues.

## Early (Pre 1960) Trends

Case management was utilized in social work practice in the late 19th century. As social work gained prominence as a formal approach to helping people in need, case management was considered a part of practice per se rather than a separate service. Case management was defined in early social work practice as a means of assisting a client with multiple needs to access appropriate services. This was accomplished through routine interactions with clients and other providers. Incorporated into daily social service practice, case management was a client centered approach to securing and coordinating the most appropriate resources available.

Through the years, the definition of case management underwent a variety of changes. Based on the literature reviewed, three constant factors existed throughout all of the definitions through the 1950's. These constant factors included the following:

1. The label "case management" was offensive to many providers and consumers, because the label suggested dependency and identified the client as a "case" rather than a person. Despite the protests and distaste associated with the label, the term has persisted because of its wide use among agencies and organizations.
2. A precise definition of case management had not been agreed to by providers, and the definition continued to vary from agency to agency.
3. The client centered focus became the stabilizing factor in the interpretation of case management.



## The 1960's and 1970's

The social, cultural and political changes of the 1960's and 1970's had a major impact on how human services were delivered, who received services, what types of services were delivered, and who paid for the services.

Five major trends occurred during that period fostering a more formalized case management process.

1. Rapid growth and specialization was occurring in the development of human services programs.

Availability of federal funds for large scale human service programs; i.e., War on Poverty, Medicaid, and increased interest in the psychosocial needs of people helped to generate the rapid expansion of the human service industry.

2. Rapid growth and specialization led to fragmentation and complexity in the system for both providers and clients.

Rapid growth in the human service industry produced the same result that such growth does in any industry-- difficulties in coordination and somewhat chaotic conditions. It became difficult for providers to keep abreast of who was providing what service to whom. As specialization increased, the system became even more fragmented. The increased fragmentation made it increasingly difficult for the client to access the system for needed services. The provider was not always able to secure the most appropriate service linkages

because he was not aware of all of the specialized services that were available.

3. The deinstitutionalization movement fostered farther need for coordination of multiple services for the multiple need client being placed in a community setting.

Federal and state statutes were enacted to provide safeguards against unwanted and unnecessary institutionalization for certain populations. Multiple need clients who were formerly placed in an institution, were now in the community setting with inadequate systems for coordinating needed services. The client himself was seldom able to handle the coordination.

4. Increased emphasis and attention was given to the individual and the social rights of the poor and vulnerable in the population.

The Civil Rights Movement, Equal Opportunity legislation, and President Johnson's War on Poverty converged, increasing the country's awareness of the needs of people and the inequities in the current system of service delivery.

5. New methods evolved in the delivery of human services including:
  - information and referral networks,
  - umbrella human service organizations,
  - public and private sharing of facilities,
  - public/private partnerships in the delivery of service,

- computer based management information systems, and
- expanded accountability standards through steps such as consumer participation in planning, quality control, evaluation and appropriate feed back.

As the human service system responded to these trends and incorporated some of the new approaches into practice, a new "role" began to emerge. The title of this role varied among agencies. Some of the frequently used titles were: systems agent, client monitor, personal care worker, and case manager. Regardless of the title, the basic responsibilities for the person carrying out this role included:

1. Making services accessible to clients.
2. Ensuring services are responsible to client need.
3. Providing continuity of care to the client.
4. Improving efficiencies in the provision of services.

#### Federal Policy Development

The federal government responded to the demands, changes and trends that were occurring in the human service industry through major legislation.

Major legislation that was passed during the 1960's and 1970's that legitimized and standardized the level of service to be provided included the following:

### President's Commission on Mental Retardation (1962)

In this legislation, emphasis was placed on the planning and administration of a continuum of care. A counselor/coordinator was assigned to every client and/or family to assist them in accessing appropriate services.

The coordinator was intended to be independent of the service providers to eliminate potential conflict of interest in planning for the client.

The family and/or guardian was considered the most logical person(s) to assume the role of coordination, if they were willing and capable of carrying out the role.

### Developmental Disabilities Act (1975)

Case management was identified as a priority service in the Developmental Disabilities Act. It was defined as:

- a group of services embracing assistance in gaining access to needed social, medical, educational, and other services;
- 'follow along' to ensure lifelong, if necessary, relationships with the client and his/her family to plan and arrange services to meet changing needs; and
- the monitoring of clients' progress toward achievement of their individual goals.

### National Institutes of Mental Health (Mid 1970's)

In the mid 1970's, the National Institutes of Mental Health proposed a comprehensive network of services and funded demonstration projects in 19 states and the District of Columbia. A major component of the demonstration projects was case management.

### Mental Health Systems Act (1980)

Case managers were specifically identified in the community mental health centers to work with discharge planners from mental health facilities to ensure continuity of care. The Act required that a case manager be designated for each client having a service plan. The case manager was responsible for coordination and implementation of the plan.

### Long-Term Care Demonstration Grants (1980)

Ten projects were funded by the Department of Health and Human Services. The goal of the projects was to clarify the ambiguities surrounding cost and outcome evaluations of various experimental long-term care projects. The experimental projects were community based projects.

## Minnesota Policy Development

During the same period that federal policy was evolving, the individual states were developing social policy that complemented the federal legislation and also addressed and specific needs of the state. Minnesota was no exception. Existing and proposed statutes and rules in Minnesota are summarized in this section. This is followed by an analysis of the current status of case management services in Minnesota based on interviews with state and county human service personnel and private agency personnel.

### Statutes and Rules

Through the 1960's and, in particular, the 1970's, the Minnesota Legislature enacted a series of statutes and rules which spurred the process of formalizing case management into a defined service. Since the early 1970's, individual program plans or service plans have been mandated. The Minnesota Hospital and Commitment Act made the counties responsible for case management through a required discharge planning process. The term "case management" is not used in all of the statutes and rules; however, key components of the case management process are referenced in many instances.

The following is a summary of the statutes and rules in Minnesota related to case management. In all possible instances, language is taken directly from the statutes and

rules rather than rephrased. Thus the presentation style is not in a consistent and single format. The language of the statutes and rules provides a direct reference for the reader.

Community Social Service Act  
Statute 256.08  
Subdivision 1 Duties of County Board

Authority and responsibility for social services to groups of individuals shall include contracting for or providing directly:

- assessment
- protection for safety, health and well being
- means of facilitating access to services for the handicapped or impaired

Community Support Programs  
Services to the Mentally Ill  
Statute 9535.0100 Definitions  
Subpart 3 Case Management

"Case Management" means a direct service provided by mental health workers to chronically mentally ill people. Essential components of case management are monitoring and supervising individual clients; assuring coordination and availability of treatment/rehabilitation/support services; and providing access for the client to problem solving resources. These activities which are essentially coordinating and problem solving functions are provided and periodically reviewed over the period of time that the case is open. It shall include, but is not limited to:

- assessment
- development and implementation of an individual program plan
- coordination of services
- providing linkages between service systems and the client
- assurance of client involvement
- influencing providers to respond to client need
- monitoring/revising of the individual program plan

- stimulating development of needed services and resources
- protecting the rights and dignity of clients

County Use of Federal Block Grant Funds  
for Mental Health services  
 Statute 245.712  
 Subdivision 1a Allowable Services

Services for chronically mentally ill individuals, which include identification of chronically mentally ill individuals and assistance to them in gaining access to essential services through the assignment of case managers.

Discharge Administrative Procedure  
 Statute 253B.20  
 Subdivision 4 Aftercare Services

The designated agency shall provide case management services, supervise and assist the patient in finding employment, suitable shelter, and adequate medical and psychiatric treatment, and aid in his readjustment to the community.

Adult Foster Care  
 Rule 9555.5400  
 Subpart 3 Copies of Written Plan

This subpart implies that the social service agency has a written plan for each resident.

Client Social Service Plan  
 Rule 9550.1500 (Rule 160)

Whether service is provided directly by local social service agency or it is contracted to another provider, a plan mutually agreed upon by the agency and the individual must be developed which:



- involves the client
- identifies the needs for service, specific service to be provided, designated provider and objectives to be achieved
- specifies frequency and reason for contact with the client
- delineates objectives and time frame for achieving them
- identifies mutually agreed upon review dates

Homemaking  
Rule 9565.1200  
Subpart 3 Use of Homemaker

The homemaker is used only as indicated by the service plan managed by the social worker.

Treatment Programs for the Mentally Ill  
Rule 9520.0640  
Subpart 1 Individual Program Plan Development

Team development of the individual program plan including active involvement of the resident unless contraindicated is mandated. It is specifically stated that the referring agency should be included on the team.

Subpart 2 Plan Contents

Contents of the individual program plan should include:

- assessment
- prioritized goals
- measurable objectives
- identified strategies or resources to accomplish goals and objectives
- identification of human resources involved
- reassessment of progress toward goal attainment

Mental Retardation  
Rule 9525.0060 (Rule 185)  
Subpart 1 General

The County Board has the responsibility to delegate case management responsibilities to the local social service agency.

Subpart 3 Assessment of Client  
Needs and Development of Individual Service Plan

The local service agency will assess needs and develop a service plan for the client with the cooperation and involvement of the client and family/guardian. The following is included in the plan:

- individual services to meet client need
- provision for implementation
- provision for ensuring delivery of services
- evaluation
- payment for service plan

Mental Retardation Rule  
9525.0015 (Rule 185) Proposed)  
Subpart 4 Case Management Services

Case management services are identifying the need for seeking out, acquiring, authorizing, coordinating, and Monitoring the delivery of services by an individual designated by the County Board to provide case management services and protecting the rights of persons with mental retardation.

Residential Treatment Services  
Rule 9565.3700  
Subpart 7 Other Assistance to the Client

The local social service agency has the responsibility to help the client to:

- maintain family and community ties
- make use of community resources
- obtain regular health and dental evaluation
- secure and utilize support services
- move to other environments when appropriate
- achieve the objectives of the plan

Self-Independent Living Services  
Rule 9525.0560  
Subpart 3 Individual Program Plan

This implies that the local social service agency is responsible for the development of an individual service plan. The individual program plan is an expansion and a refinement of the individual service plan.

Preadmission Screening and Alternative  
Care Grants Program  
Program Manual IV-C  
How ACG Funds Are to be Used

Case management is a designated waived service.

Program Manual Appendix B  
Definition of Case Management

It is not assumed that all persons requiring alternative care services will require case management. The need for case management will be made by the screening team when developing the plan of care. If the individual requires a combination of two or more services, the screening team may determine that case management is necessary to assure timely and appropriate delivery of services.

The case management service is a primary component of the home and community based plan of care. In many instances, it will be critical to the recipient's ability to remain outside of an institution . . . The responsibility of the case manager is to assure continuity of care, coordination of the total service care plan, and monitoring of the service delivery so the health and safety of the client is protected. Specific responsibilities include:

- assuring that a valid assessment was made by the screening team
- determining that the plan of care meets the requirements of the individual

- obtaining the necessary documentation of service need, including physician signatures when necessary
- initiating and maintaining contact with service providers to ensure that agreed upon care is being provided
- initiating and maintaining contact with family members and other informal care givers to ensure that agreed upon care is being provided
- re-evaluating the total plan of care so that services are added or deleted as appropriate
- monitoring the recipient's health and safety and initiating reassessment when indicated by recipient's care needs
- checking on quality of care provided to ensure that the recipient's health and safety is being maintained
- providing ongoing coordination of total service plan so that cost does not exceed cost limits determined by comparable institutional care

Proposed Amendment to Chapter 256B.09 Establishing Pilot programs with Local screening Teams and Case Management Efforts for Mentally Ill Persons

The proposed amendment is to establish case management for the mentally ill.

The case management process is described through the duties of the case manager and include:

- assuring that a valid assessment is made
- convening an interdisciplinary team for the purpose of developing an individualized program of treatment plan with specific planned outcomes and that meets the requirements of and includes input from the individual; this team may be the same as the screening team. The minimum team membership shall be a county social services worker, a county public health nurse, a mental health professional, and any others needed to meet the needs of the client
- obtaining the necessary documentation of service need, including releases of information and diagnosis in accord with Rule 29
- initiating and maintaining contact with service providers to ensure that agreed upon care including achievement of planned outcomes is being provided;

- re-evaluating the total individualized program plan so that services are added or deleted as appropriate including recommendations for termination from case management services
- at least quarterly monitoring of the recipient's health, safety, mental and social functioning levels and initiating reassessment when indicated by the client's service needs
- at least quarterly monitoring of services delivered and the quality of care provided to ensure that the client's health, safety, mental, and social functioning levels are maintained
- providing ongoing coordination of the total individual program plan
- preparation of reports including identification of unmet needs due to lack of community resources which may be required by the commissioner of human services.

#### Status of Case Management in Minnesota

Even though Minnesota's policy development identifies a movement toward formalizing a case management system, no formalized or clearly defined system exists today.

In order to assess the status of case management in Minnesota, interviews were conducted with a number of human services personnel including state, county, and private agency personnel. The persons interviewed are identified in Appendix A. The following summarizes the results of these interviews.

Definition of Case Management:

The majority of individuals interviewed agreed that the following steps were part of the case management process:

- comprehensive assessment;
- client program plan;
- program coordination; monitoring of service delivery; and
- reassessment and evaluation.

Resource allocation was not identified as a separate step as is done in the integrated model presented in this report. In addition, a few individuals considered the comprehensive assessment as a process which must occur before case management, rather than as a part of case management. For example, the current Alternative Care Grant program for the elderly in Minnesota does not include or pay for assessment as a part of case management.

While each interviewee defined the process in slightly different terms, the basic philosophy underlying all comments was that case management is a client centered process designed to assist the client to "broker" the human service delivery system to meet his/her needs.

Though all of the counties interviewed were providing some form of case management services, the following was apparent.

- All counties interviewed are attempting to develop and refine case management models for various populations. No one has an integrated model that addresses all adult target populations.
- Case management services have been used in some instances as a "catch-all" category for services provided. Thus there is currently no data available regarding time and costs for a case management in which people have confidence.
- Olmsted County personnel are in the process of developing standards for levels of case management and are using the standards for budgeting purposes. They consider the standards "untested" at this time and based on their best guesses. Appendix C is the definitions and standards that they had developed at the time of the interviews. Work was in progress on elderly services.

#### Role of the Case Manager

The issue of accountability was a constant theme in discussions of the role of the case manager. In general the interviewees felt that one person must be accountable to the client and the payer (often the county or the state), and that person should be the case manager. The case manager must be the person ensuring that the client receives the identified services in the plan in a timely and satisfactory manner.

Another major concern of the interviewees was how the role of case manager was assigned. Some felt it should be determined by the specific needs of the client. For example, a client with mental health needs should have a case manager who has expertise in mental health services. Others felt the

county social worker should be identified as the case manager, regardless of the specific needs of the client, because the county is the source of funding.

The third point that was emphasized was the relationship between the case manager and the client. The majority of interviewees felt that the relationship must be ongoing, with regular interaction and based on trust if the case management process is to be effective.

#### Population Specific Needs Identified:

The following population specific needs and concerns were identified:

Chemical Dependency - The majority of clients flow in and out of the system fairly fast, and often times the opportunity to develop a long-term relationship with these clients does not occur.

Elderly - The primary needs of the elderly tend to be health related. The need for public health nursing involvement is most important with this particular population. Some controversy exists regarding the appropriate case management for this group.

Mentally Retarded - At the present, case management services are only available to mentally retarded persons wanting services the county pays for. Case management would be valuable for all clients who are mentally retarded.

Mental Illness - Case management for the mentally ill requires significantly more time than for persons who are mentally retarded or physically disabled, because the mentally ill are less predictable and stable.

Physical Disabilities - Private agencies feel county experience in working with the physically disabled is limited in most instances.



### Rural County Problems:

The rural county personnel expressed concerns unique to the rural areas that impact the development of case management services.

First, most rural county social workers are generalists and work with all groups receiving county services. Thus, the workers feel strained in keeping up with developments for each population group.

Second, interviewees felt that training was essential to help county social workers understand and appreciate the power and influence inherent in the case manager role. The majority of the workers view case management as an additional administrative burden at this time.

Third, there is considerable concern that sufficient time will not be budgeted for case management and already overburdened case workers will have case management added to responsibilities. This concern relates directly to the point of view of the county board in budget allocations.

Fourth, several interviewees felt that it would be valuable in the rural counties to have a person who is a case management specialists. This person would be responsible for organizing the case management process and assembling groups of providers. This person would not be a case manager but ensure that the case management process occurred.

Summary of Status of  
Case Management in Minnesota

The conclusions reached by the consultants after interviews and discussions with persons at the local level and involved in service delivery include the following:

- Many counties are providing some forms of case management services to different populations. However, few have carefully defined what case management is and what specific activities are "counted" as case management. Thus it is difficult to gather data or evaluate case management services.
- Budgets for training and additional staff are a significant concern in implementing case management systems in many counties. Unless training and time are provided, most workers at the local level will strongly resist case management.

One of the more developed rural model case management systems is the system being developed in Meeker, McLeod and Sibley Counties through a three year McKnight Foundation grant to the Community Health Services Agency. The model is currently being used with the elderly population and will be extended to other adult populations. The data from the first two years of development is currently being computerized and preliminary reports will be available in February, 1985. Potentially valuable data from this system will be the identification of time spent in case management activities because the project has clearly and specifically defined what case management is. Part of the commitment of the McKnight Foundation is to summarize and share the data with

policy making organizations and people to provide input into the development of case management services. The experiences from this project and data that is developed will be valuable in the development of case management services in Minnesota.

#### Case Management: The 1980's

In the previous discussion, the primary focus of case management as it had evolved was to deliver services to the client in an orderly manner while being responsive to client need.

By 1980, case management was being increasingly viewed as a major process for controlling costs through managing the multiple problem client in the community setting.

In Meeting the Crisis in Institutional Care: Toward Better Choices, Financing and Results, the Citizens League examined the rate and high cost of institutional services for various target populations in the State of Minnesota. The report contends that there is a growing body of research that shows that non-residential forms of care can be as effective or even better than residential care for some people and much less expensive.

The report also highlights that the predominant response to dealing with the at risk population in Minnesota remains an institutional bias in 1984. The reasons for this

involve both a financial incentive in most instances for the counties to use institutional services, and the lack of available community resources outside of the institution.

The case management system is generally believed to be essential for the management of at risk individuals in the community in accessing and securing appropriate services to remain in the community setting.

The focus of case management in the 1980's is a focus that is definitely oriented to more authority and accountability for the case manager in determining client service needs and in ensuring that those service needs are met by the designated providers. In some of the reviews and discussions related to this project, there was concern expressed regarding the potential conflict for the case manager functioning in a dual role of accountability for use and cost of services and client welfare and advocacy.

## CASE MANAGEMENT: AN INTEGRATED MODEL

### Overview

The following section presents a description and model of the case management process including articulation of the role of the case manager in each phase of the process.

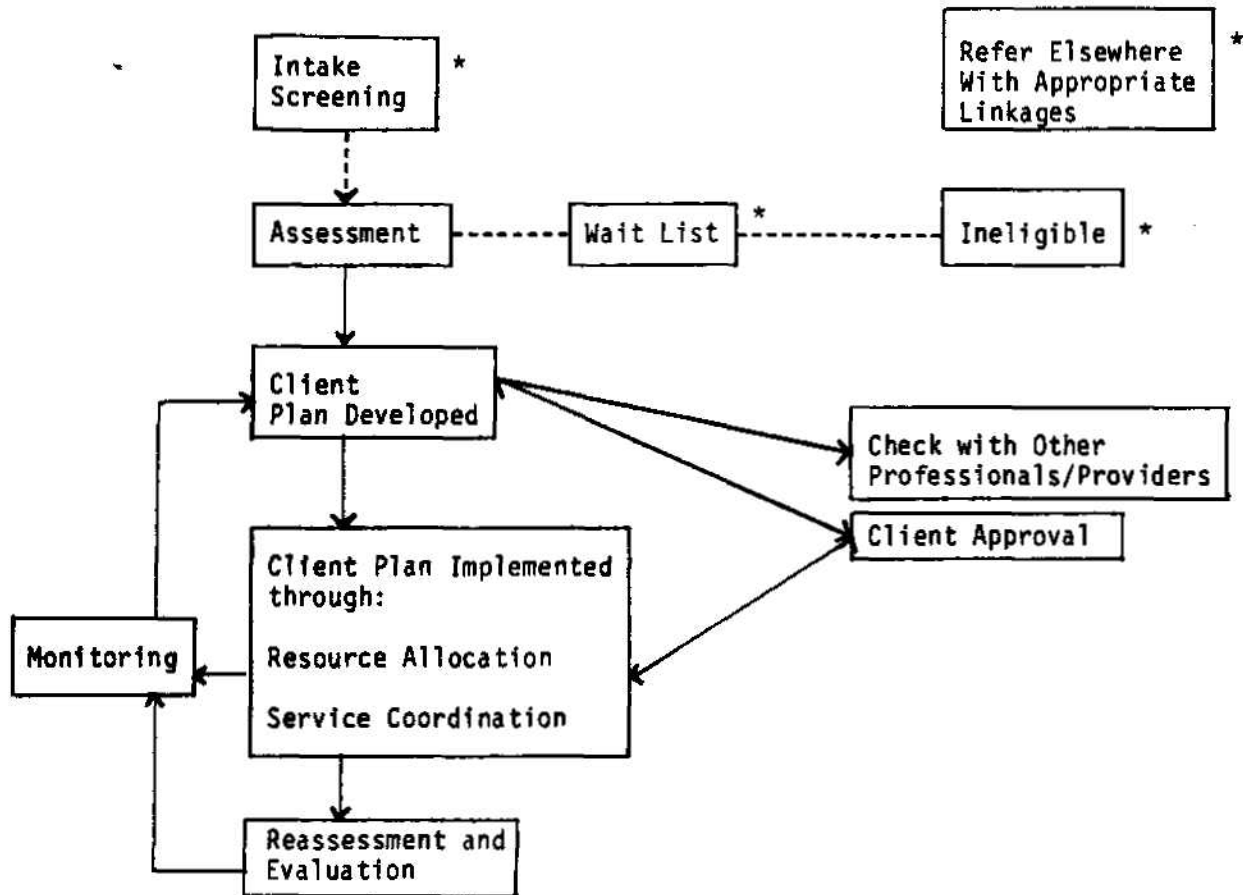
The proposed model is intended to be applicable to all adult at risk populations: elderly, chemically dependent, chronically mentally ill, mentally retarded and physically disabled persons. The basic components of the model are applicable to the case management process for all target populations.

The model presented does not have the specific endorsement of any of the reviewers listed in Appendix B. The authors present this model as their concept of a workable model based on the interviews, literature reviews, and model review with key providers.

### Model

Figure 1 presents the proposed model, graphically. The components are described in the following narrative. The role of the case manager is articulated for each phase of the process.

FIGURE 1  
INTEGRATED CASE MANAGEMENT MODEL



\*These items are not a part of case management.

Adapted from a model presented in Planning Handbook  
Community Based Long-Term Care, California Department  
of Aging, Sacramento, California, December 1982.

The model identifies four components that are not part of the formal case management process, but indicate what can occur with a given client entering the system. The intake/screening process is differentiated from the assessment that is a part of case management. The intake/screening process is perceived as a process to determine the eligibility of a client for obtaining certain services. For example, for an individual who is mentally retarded, the initial process is simply an affirmation of the fact that the person is diagnosed as retarded and is, therefore, eligible for certain services. After the assessment process that is a part of case management, a person may be determined not to need case management services or not be eligible, based on the assessment, for case management. Such persons are referred elsewhere in the human service system. The wait list is included to indicate that persons may be in need of case management services, but resources for such services may not be available; i.e., financial, human.

#### Definition of Case Management

Case management is defined as follows:

Case management is an active, dynamic process aimed at maintaining the client in the most appropriate (least restrictive within available resources) environment through identifying needs for, seeking out, acquiring, authorizing, coordinating, and monitoring the delivery of services.

The process is carried out by an individual designated (by the County Board for county agency case management) to carry out the case management process. This individual is designated the case manager.

The case management process assumes a primary focus of protection of the rights of the client, principally through the active involvement of the client and/or family/guardian in the case management process.

#### Components of the Case Management Process

The case management process involves the following components:

1. Comprehensive Assessment
2. Development of Client Plan
3. Allocation of Resources
4. Service Coordination
5. Monitoring of Service Delivery
6. Reassessment and Evaluation

All components of the case management process assume a central role and the full participation of the client and/or guardian.

#### Components Defined

The following defines the various components of the case management process including identification of the authority and responsibility of the case manager, and other providers both formal and informal.



ASSESSMENT:

The client assessment provides the case manager with a comprehensive guide for the development of a plan for the client that includes long range client goals, specific time-bound outcomes for the client's functioning, and identification of services to achieve the desired outcomes and long range goals.

The assessment entails a thorough exploration of the client's current status including:

- social;
- physical;
- functional;
- emotional; and
- psychological.

The assessment addresses the following:

- ability of the client to meet basic needs of food, shelter and clothing;
- adequacy of the living environment;
- ability of the support network to assist the client;
- availability of recreational and social activities;
- ability to pursue vocational training and/or employment; and
- adequacy of financial resources.

The assessment is done to specifically identify how and in what areas the client is dysfunctional or is anticipated to be dysfunctional without appropriate services.

The assessment must also identify what can reasonably be expected of the client in relationship to the above.

### ROLE OF THE CASE MANAGER IN ASSESSMENT

The following articulates the role of the case manager in the assessment process;

- conduct and/or participate in the assessment process;
- involve other providers as appropriate in completing the assessment;
- involve the client in all aspects of the assessment, and ensure that other providers appropriately involve the client in their phases of the assessment;
- involve the family and the informal support network that exists in the assessment and ensure that other providers appropriately involve the family and informal support network;
- conduct the assessment and ensure that other providers conduct their portions of the assessment in the most appropriate setting for the best results; e.g., in the client's home to assess functional capabilities and adequacy of skills in independent living activities;
- coordinate and collect all aspects of the assessment for the client record; and
- ensure completion of the assessment and make the appropriate social/health diagnosis.

### CLIENT PLAN:

The client plan is an outcome-oriented, time-bound statement of general client goals for rehabilitation and/or maintenance of the client in the most desirable and least restrictive environment. The plan states specific outcomes to be achieved in relationship to the functioning of the client.

The program includes the following:

- concrete definition of client needs in relationship to the client's functioning in the desired setting, related directly to the data and other results produced from the assessment;

- identified goals and specific time-bound outcomes desired for the client and stated in terms of the functional status of the client in all designated areas;
- description of specific services to be provided for the client in direct relationship to that service accomplishing the desired outcome; the following should be identified:
  - provider to provide service, frequency of service to be provided, setting for service delivery,
  - specific responsibility for having client at desired setting at desired time,
  - payment source for services,
  - identified gaps in needed services and how such gaps can be compensated for in the plan, outcome associated with each service.
- specific dates for reassessment and evaluation of all goals, specific outcomes, and designated method of reassessment and evaluation.

#### ROLE OF THE CASE MANAGER IN CLIENT PLAN:

The following articulates the role of the case manager in the develop of the client plan:

- develop in writing a plan for the client that meets all of the identified criteria including food, shelter, health care, that provides the care in the least restrictive environment, that is oriented to the full functioning of the client, and that increases access of the client to the community;
- coordinate the full participation of the client and/or family/guardian in the development of the plan;
- involve other providers as necessary in the development of the plan;

- coordinate the participation of the informal support network in the development of the plan as necessary and desirable; and
- secure commitment to the plan through the client's and/or family/guardian's signing of the plan and communicating commitment to the case manager to fulfilling the plan.

#### RESOURCE ALLOCATION:

Resource allocation involves the case manager's authorization of the specific services identified in the plan. Resource allocation involves:

- authorization of funds when appropriate for designated services;
- comprehensive knowledge of the provider network for availability, accessibility, affordability and quality of various services and service providers;
- establishment of working relationships with the provider community to communicate and/or assist the client in communicating specific desired outcomes of service; and
- termination of the authorization of certain services if in the reassessment and evaluation process, the services are determined no longer needed and/or are not accomplishing the stated outcomes.

#### ROLE OF THE CASE MANAGER IN RESOURCE ALLOCATION:

The following articulates the role of the case manager in resource allocation:

- authorizes or ensures the authorization of appropriate funds for services; and
- terminates authorization for funds for services when appropriate.

#### SERVICE COORDINATION:

Service coordination involves the necessary activities to coordinate the delivery of the identified services to the client. Such coordination includes:

- fostering of working relationships among the various providers providing service to the client, to ensure that services are coordinated and complementary and that the desired client outcomes remain the focus of the service delivery;
- assistance for the client in brokering services from the provider community;
- advocacy for the client in working with the various providers; and
- ensuring of involvement of the family and in formal support network in the delivery of services.

#### ROLE OF THE CASE MANAGER IN SERVICE COORDINATION:

The following articulates the role of the case manager in service coordination:

- provides the necessary service coordination functions or ensures that they are provided; or
- ensures that the necessary service coordination functions are provided.

#### MONITORING OF SERVICE DELIVERY:

Monitoring is the "check and balance" component of the case management process. As such, monitoring should be an ongoing activity in case management and requires contact with the client and/or family/guardian and the various service providers to ensure that:

- the client is receiving the designated services in a timely manner;
- the service is of expected and adequate quality;
- the client is benefiting from the service; and

- the service continues to be the most appropriate service for achieving the identified client goals and outcomes.

#### ROLE OF THE CASE MANAGER IN MONITORING OF SERVICE DELIVERY:

The following articulates the role of the case manager in monitoring the service delivery:

- directly monitors or ensures that monitoring is done to determine whether the client is, in fact, receiving the designated services in a timely manner and that the service is of expected and adequate quality;
- monitors on an ongoing basis, the benefit the client is receiving from the service and the continued appropriateness of the service for the achievement of client goals and desired outcomes; and
- makes necessary changes in the providers of services and/or in the service provided in relationship to achievement of the client goals and desired outcomes (including both formal and informal providers of service).

#### REASSESSMENT AND EVALUATION:

Reassessment and valuation identify changes which have occurred over a given period of time in the client's status in the current setting. Reassessment and re-evaluation include the following:

- identification of changes in the status of the client through participation of the client and/or family/guardian as well as other service providers and including the direct observations and interactions of the case manager with the client;
- re-evaluation of the client program plan to determine continued appropriateness of:
  - goals and functional outcomes that were established for the client;

- services designated to achieve the outcomes;
- continued commitment of the client and/or family/guardian (and informal support network) to participate in the rehabilitation and/or maintenance of the client in the given setting; and
- revisions of the client program plan to meet all criteria previously established for the development of the client program plan.

#### ROLE OF THE CASE MANAGER IN REASSESSMENT AND EVALUATION

The role of the case manager in the reassessment and evaluation is articulated in the following:

- conducts the reassessment and evaluation as determined in the client program plan;
- involves other providers as necessary in the re-assessment and evaluation process;
- involves the client and/or family/guardian in the establishment of new goals, new outcomes and/or other modification in the program plan;
- authorizes changes in service delivery when appropriate; and
- ensures that the client is reintegrated into the resource allocation and program coordination process.

#### Role of the Case Manager in Fiscal Responsibility and cost containment

The principal role of the case manager as the advocate of the client, ensuring that the client receives the needed services in the complex human service delivery system, is not necessarily compromised when the dimension of fiscal responsibility and cost containment are added to that role.

The role of the case manager in relationship to fiscal responsibility and cost containment includes the following:

1. In order to foster maximum independence for the client, the case manager must address responsibility with the client. Such an emphasis teaches the client that resources are limited and must be maximized to ensure that the client can remain in the setting of his choice.
2. The case manager, as the client advocate, has to work within available resources, including policies established by federal, state and local government, to maintain the client in the desired and least restrictive setting. Those policies are governed by the need to contain costs, limiting the maintenance of the client (in most instances) in the community setting chiefly if costs are less than the institutional setting.
3. To provide the optimal level of service within financial constraints, the case manager must know and/or be able to do the following:
  - develop and maintain working relationships with the various providers available to ensure that qualified providers are linked with the client, that the providers selected to provide service are committed to working cooperatively to accomplish the client's goals, and that the providers do, in fact, delivery the identified service;
  - develop and maintain working relationships with the family and friends to continue their involvement with the client through the informal support network;
  - develop and maintain skills to make integrated and longer range decisions about the optimal use of resources, eliminating a perspective that provides limited, low cost services that may not be the most cost effective overall plan for the client; e.g., not authorizing an appropriate level of more costly skilled rehabilitative services;



4. The case manager has the authority and responsibility to ensure that all phases of the case management process are carried out through eliciting the support and cooperation of the client. Thus, the case manager is acting in a fiscally responsible manner as well as in the best interests of the client as an advocate when she no longer uses a provider that does not deliver an agreed upon level of service or does not work co-operatively with other providers.
5. Through using his authority and responsibility in the case management process, the case manager can ensure that the public dollars that are utilized for services for the client provide the maximum return for the client. This is, in turn, the maximum benefit for the dollars invested from the public sector.

## ISSUES IN THE IMPLEMENTATION OF AN INTEGRATED CASE MANAGEMENT SYSTEM

### Overview

The case management process is relatively easily defined and is an accepted concept in the delivery of human services. In addition, there appears to be a reasonable degree of consistency and agreement regarding the components of the process. In the review done for this project, over 20 definitions of case management representing all of the various target populations contained essentially the same components in the process.

However, the implementation of an integrated case management system presents a series of significant issues that need to be addressed. This section of the report identifies the relevant issues, and the recommendations that follow in the final section address the identified issues.

### Role of the Case Manager

Some persons involved in social work practice claim that the current discussions of case management simply define a role that has been an inherent part of social work practice since the turn of the century. In fact, they argue that case management should not become another "job description" in human service systems, but rather recognition should be given

to the fact that the role has always existed and is simply being formalized today.

Others argue that the discussions focusing on the need for case management services to maintain the client in the least restrictive environment and to control use of the resources is different from the "traditional" role of the social worker. In fact, persons in this position argue that case management is not currently taught in schools of social work necessitating extensive training programs for implementation today.

Part of the problem is directly related to the caseloads that social workers are expected to carry in most counties today, eliminating the possibility of having time available to carry out case management as it is defined in the model presented in this report. Standards regarding caseloads is discussed in a later part of this section.

Another area of significant disagreement regarding the role of the case manager is whether the case manager can also provide direct services to the client. Some persons argue that the provision of direct services to the client is an important part of developing the necessary relationship with the client and actually enhances the functioning of the case manager. Others argue that if the case manager is responsible for ensuring that the appropriate services are delivered and delivered in an acceptable manner to the client, the case

manager cannot be the provider of any of these services. The argument is that the case manager is not likely to effectively evaluate the quality and adequacy of his/her own services. Finally, smaller county personnel indicate that it is simply not practical to consider separate staffing for case management and service delivery. Human resources would not be available even if the money were available. In most instances, there is not adequate funding to consider such a staffing pattern.

Some providers perceive a conflict between the role of the case manager as a client advocate and the fiscal responsibility of the case manager in relationship to use of agency resources. Some argue that the case manager should be concerned only with securing the resources he/she feels would be most to the advantage of the client.

Many persons argue that the case manager must be given the authority and be expected to be accountable for the services provided to the client in accordance with the service plan. The case manager, in order to be effective, must perceive herself in charge of managing the service providers. This would include terminating providers who do not meet accepted standards and/or are not achieving the anticipated results with the client. Others argue that such a role and such an approach puts the case manager "at odds" with the provider community and makes it more difficult to provide

service coordination. Finally, the reality in many smaller communities is that there is no choice available among service providers and the case manager must accept what is available.

Team versus individuals as case managers is an area of concern regarding the role of the case manager. Some argue that the multi-disciplinary team is frequently necessary in providing case management services to the client. First, the multi-need client is generally the client in need of case management services. The needs of the client cross program areas and areas of expertise. Thus, "teams" are more effective than individuals. For example, health is frequently involved in needs of the elderly in the community setting. Thus, a social worker/public health nurse team will do a better and more effective job in case management than one. Because the client in need of case management is frequently a multi-need client with heavy demands, persons who have functioned in the "team" model argue that the team approach helps prevent burn-out. Teams also feel that the client receives better services because the members of the team have different strengths and perceptions and are able to relate differently to the client. Others argue that the use of more than one person in case management should be an individual decision related to the needs of the particular client. In addition, if a "team" becomes the case manager, it is necessary to have a single person as the primary case manager to ensure the appropriate accountability. This primary case

manager is accountable within the system for the case management process. Again, the rural counties argue that there are simply not resources available to implement a team approach to case management. It is frequently difficult to obtain the necessary professionals to do portions of the necessary assessments.

Finally, the majority of the literature and persons interviewed agree that in order for case management to function effectively, the case manager has to be accountable for the accomplishment of specific plans for the client. Thus, the case management function in an agency has to be adequately supervised to be effective. In addition, the agency needs to establish appropriate policies, procedures, and goals for case management services.

#### Qualifications of the Case Manager

The qualifications of the case manager relate directly to the role of the case manager. In Minnesota today, the Preadmission Screening and Alternative Care Grants Program has requirements for the screening team and the case manager. The proposed Rule 185 for the mentally retarded population has specifically delineated qualifications for the case manager. Finally, the proposed program for the mentally ill has some requirements. The following describes the qualifications.

Preadmission Screening and Alternative  
Care Grants Program

The Preadmission Screening and Alternative Care Grants Program distinguishes two levels of requirements that are part of the proposed integrated case management model.

The program has a "screening" component in place of the assessment process in the defined model. The screening team becomes responsible for developing a plan of care. At the current time, "screening" is not defined as part of case management.

Requirements for the screening team includes the following:

1. The screening team must include a public health nurse from the county public health nursing service, a social worker from the county welfare agency and the individual's attending physician, if the physician chooses to participate, or a consulting physician when necessary. Counties do have the option to contract for hospital screenings with other agencies.
2. The nurse member of the county screening team must be a certified public health nurse. It is recommended that the nurse be knowledgeable about long term care services (both community based and institutional), be sensitive to meeting the needs of the elderly and be familiar with group and family dynamics.
3. The social worker on the county screening team must be the equivalent of a Social Worker I under the county welfare merit system. It is recommended that the social worker be knowledgeable about community and institutional long term care services, be sensitive to meeting the needs of the elderly, and be familiar with group and family dynamics.

Requirements for the case manager include:

- The screening team should designate a case manager who will be responsible for monitoring and ensuring compliance with the plan of care. When needed, the case manager may recommend a re-evaluation by the screening team. The case manager may be a county staff member, family member or other appropriate person. If the client is receiving alternative care grant funds, the designated case manager must be either a county public health nurse or county social worker.

Rule 185 for Mentally Retarded Emergency Rule

Each case manager must have at least the qualifications in Items A. and B.:

- A. Each case manager hired after December 31, 1984, shall meet the requirements for a qualified mental retardation professional or have a bachelor's degree in a field related to the education and treatment of persons with mental retardation and at least one year of experience in the education and treatment of persons with mental retardation.
- B. In addition to the qualifications in Item A., each case manager shall complete at least 20 hours of training and continuing education in case management and mental retardation services each calendar year. The county board shall maintain a written record of all training and continuing education completed by all case managers employed by the county board.

Proposed Amendment to Chapter 256B.09 Establishing Pilot Programs With Local Screening Teams and Case Management Efforts for Mentally Ill Persons

The proposed amendment at the stage at which the authors had copies included the following:

1. Screening teams are to be designated in each county and are composed of at least three persons including a county social worker, a county public health or certified public health nurse, and a mental health practitioner or professional. If a mental health professional is not on the screening team, the professional shall be available for consultation.



2. There are no specific qualifications designated for the case manager other than each case manager shall serve no more than 25 persons.

If the role of the case manager includes the delivery of services to the client, certain qualifications become mandatory; e.g., health services require a nursing license. Some persons argue that if the case manager is to evaluate the adequacy of services provided to the client, the case manager has to be reasonably conversant with different types of treatment processes and service delivery in order to determine whether they are provided in an adequate manner. Others argue that a "generalist" with excellent communication and relationship skills will make the best case manager and that specific professional qualifications are not useful. One author suggested that paraprofessionals would make better case managers because they are less rigid in their definitions of the social service system, more flexible and creative in seeking services for clients, and less likely to disdain the "drudgery" associated with case management.

Significant concern exists in the rural counties regarding the adoption of qualifications for case managers that may exceed the available resources. The more requirements that are attached to the qualifications for case management, the more difficult it may become for smaller counties to obtain and retain a qualified number of persons to be case managers.

In addition, if different groups in the system define specific qualifications for case managers; e.g., elderly, mentally retarded, mentally ill, etc., smaller counties will not be able to obtain or afford the qualified personnel. As previously mentioned, many of the counties in Minnesota have three or fewer adult workers on the entire staff.

#### Components of Case Management

Though the components of case management appear to be relatively consistent in the literature reviewed and in discussions with the various providers, several concerns need to be addressed.

Some persons feel that assessment precedes case management and is not a part of case management. The Preadmission Screening and Alternative Care Grants Program does not include screening as a part of case management.

Another area of concern voiced in a meeting held at the State and in the review of drafts of this document concerned the inclusion of outreach as an integral part of the case management model. The consensus of participants at the meeting, the majority of the literature reviewed, and the persons interviewed expressed awareness that outreach must occur throughout the delivery system to reach clients who will go without services if expected to seek services on their own. However, outreach is an overall and ongoing responsibility of

the entire social service agency and is not a part of a specific case Management model. The outreach efforts locate and encourage persons to be assessed and, depending on the outcome of the assessment, be provided case management services.

The more uniform the definition of the case management process, the easier it will be for the counties to implement case management systems.

#### Training for Case Management

The literature reviewed and the persons interviewed placed significant emphasis on the importance of training in the implementation of case management systems. Emphasis was placed. In most instances, on the need for the development of a basic training program at the State level based on agreed upon models for case management. Many literature sources argued that the current academic curriculum are not teaching case management skills as they are being discussed today. Because of this, training will have to occur on the job.

A particular model for training suggested that the core curriculum can be developed and taught throughout a state and specialized modules can supplement the basic training and be used by the appropriate personnel. The need for ongoing continuing education was also emphasized.

A key issue is that the development and provision of training programs (including ongoing training) can be an expensive proposition. The majority of the counties are going to need significant assistance in case management training and do not have the resources locally to provide the training.

#### Caseload Standards

There are no standard definitions of optimal caseloads for case management. Anecdotal Information in the literature seems to favor caseloads of under 25 to provide optimal services. However, caseloads of over 100 are reported.

Optimal caseloads are partially dependent on the mix of clients that are being served in case management.

Until uniform definitions are developed for case management and record keeping systems count and record the same things, it will be difficult to arrive at any guidelines or definitions related to caseload. Data was provided by a number of counties regarding case management hours; however, the majority of persons providing data suggested extreme caution in using the data to arrive at any useful conclusions.

The most significant concern among workers in the field is that sufficient time will not be given to them to carry out case management functions; yet they will be expected to be case managers. Such a situation produces anxiety and

frustration for the worker as well as creates a negative attitude toward the case management process. As previously reported, many workers in the field perceive case management at this point as more administrative work.

Finally, various providers caution that the reimbursement system for case management services should be structured in such a way that volume alone is not rewarded in the provision of case management and other services. If counties are "rewarded" for volume, workers will undoubtedly be assigned large caseloads.

#### Contracting Case Management Services

Some persons feel that case management services should to be contracted by the county to any other agency. The case management process is at the heart of local government accountability for expenditure of public funds. Thus, case management should be retained within the county agency while service provision can be contracted to other organizations.

#### Integration of the Human Service Delivery System

Some argue that in order for case management systems to be effective, the human service delivery system has to be integrated more effectively than it is at the State as well as the local level. Because the policy development and delivery of human services in most states is fragmented, the case

management system will have difficult functioning effectively.

### Summary

The recommendations that follow respond specifically to the issues that have been presented in this section of the report.

## RECOMMENDATIONS

### General

An integrated case management model applicable to all adult target populations is necessary, particularly for the smaller counties, if an effective case management system is to be developed in Minnesota.

### Role of the Case Manager

- (1) Separation of the case management role from the delivery of services is the most desirable system, and should be implemented where feasible.
- (2) In many instances, it will not be possible because of limitations in resources, to completely separate case managers from service delivery. Thus, such separation should not be mandated.
- (3) In those instances where it is necessary to combine the role of case manager with service delivery, counties should be required to have appropriate supervisory and peer review processes to insure that service delivery is adequately monitored and evaluated.
- (4) The Department of Human Services should provide appropriate education for the counties to ensure:
  - that county boards understand the role and importance of case management, including an understanding that appropriate time needs to be allocated for case management responsibilities
  - that county directors and staff understand case management, including and emphasizing accountability for client management as well as resource utilization
- (5) The needs of the client should determine whether a "team" or individual case manager should be assigned. In the event that a team approach is used, a single individual should be designated the primary case manager for accountability.

### Qualifications of the Case Manager

- (1) Maximum flexibility should be maintained in the mandated qualifications for a case manager; however, this flexibility should begin with the recognition that the case management role is a "professional" role that requires training and experience.
- (2) If a case manager is handling more than a single adult population, qualifications should exist to ensure that the case manager knows enough about the population being served to adequately plan, monitor and evaluate services for the client.
- (3) Case managers not trained in a specific area, e.g., mental illness, will need to use consultants as part of a "team" to ensure adequate planning, monitoring and evaluation.

### Components of Case Management

The model that was previously presented is the consultants' recommendation regarding the components of a case management system.

### Training

- (1) The Department of Human Services should assume primary responsibility for training for the counties. This should include making ongoing continuing education available for the counties.
- (2) The Department of Human Services should work with the Vocational Technical Institutes and the Community Colleges to develop ongoing training programs for case management that are both preparatory as well as continuing education. Such development can be facilitated by assistance in developing curriculum and training instructors.



#### Caseload Standards

- (1) A common set of definitions related to case management activities should be developed.
- (2) These definitions should serve as the basis for developing a reliable data collection process regarding time allocated for case management activities.
- (3) Reliable data should be gathered prior to the establishment of standards and guidelines regarding time allocation.
- (4) After sufficient data gathering and analysis, minimum standards related to caseloads should be established by the Department of Human Services.

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Minnesota Rule 9565.1200, Homemaking.

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Minnesota Rule 9525.0060, Mental Retardation.

Minnesota Rule 9525.0015, Proposed Rule to Replace 9525.0060.

Minnesota Rule 9565.3700, Residential Treatment Services.

Minnesota Rule 9525.0560, Semi-Independent Living Services.

APPENDIX A  
INTERVIEWS

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APPENDIX C

LEVELS OF CASE MANAGEMENT

DEVELOPED BY

OLMSTED COUNTY DEPARTMENT OF SOCIAL SERVICES

# CHEMICALLY DEPENDENT

Refers to any person who abuses chemical substances to the extent that they are unable to function at their full capacity and provide for their basic needs. They may also be of eminent danger to themselves or others.

Service Level	Category	Amt. of Service	Avg. Monthly Caseload	Total Time (Month)
1	Maintenance	½ hr/mo	23	12
2	Moderate	1 hr/mo	29	29
3	Intermediate	3 hrs/mo	32	96
4	Intensive	6 hrs/mo	21	126

## Description

Level 1:	Individuals in residential placement; brain damaged clients (Korsakoff's psychosis, Wernicke's syndrome); elderly chronic but stabilized clients; resistive clients who are in need of protection services; clients who require an open social case for monetary reasons (GA, CW/GR, GAMC, etc). The social worker attends teamings and reviews the direct service plan from the facility.
Level 2:	Stabilized clients usually with more than 6 months of sobriety; clients adjusting to return to community from extended care facilities where sobriety was stabilized. The social worker provides counseling to reinforce stability.
Level 3:	Unstable clients usually in the first 6 months of sobriety; usually unemployed; minimal insight into disease process and related behavior patterns; no established attendance at AA or other support group; volatile emotionally with health issues. The social worker provides the primary support counseling and coordinates the use of other resources.
Level 4:	Resistive and ignorant that they have alcoholism or chemical dependency and problems; usually have outside forces escalating intervention (job, health, legal, family, and/or financial);

dually dependent--MI/CD, MR/CD; violent towards self and others; passive/aggressive and fatalistic regarding disease -- no hope/can't change attitude. The social worker provides crisis intervention and court involvement.

Projections for 1985: To provide the above mentioned levels for an average of 103 cases will require 3,156 hours per year. Our staff complement will be able to provide 3,120 hours.

## MENTALLY ILL

This category includes any person with a diagnosed mental illness or mental disorder which impairs judgment and manifests itself by the inability of the person to provide for their basic needs. They may also, due to their illness be of eminent danger to themselves or others.

Service Level	Category	Amt. of Service	Avg. Monthly Caseload	Total Time (month)
1	Maintenance	½ hr/mo	50	25
2	Moderate	1 hr/mo	38	38
3	Intermediate	3 hrs/mo	20	60
4	Intensive	6 hrs/mo	35	210

### Description on

Level 1:	Client is residential structured placement; chronic MI's or first time placement; clients experiencing periodic depressions, some suicidal thoughts; meds which control behavior are being taken regularly; a support system is in place and being used; the client is cooperative. The social worker would attend teamings.
Level 2:	Client is living independently and resistive; experiencing medical problems; history of discontinuing medications; withdrawn; identified as having personality disorders; family worker provides counseling and support services.
Level 3:	Client recently discharged from treatment; client is unreliable with medications; diagnosed CD but under control; actively delusional; self abusive (burning, cutting, stabbing); assaultive towards self and others; actively suicidal in thought and behavior; sexual problems of higher intensity, possibly incest; abuse, homosexuality issues surfacing: family relationship problems. The social worker coordinates community services and provides supervision.
Level 4:	Chemical interfere with mental illness--diagnosed CD and MI; preoccupation with sexual problems - interfere with sleep and functioning; acting

out sexual problems; active suicidal behaviors--emergency room admissions; borderline to hospital admission. The social worker provides crisis intervention, pre-petition screening and protection.

Projections for 1985: To provide the above mentioned levels for an average of 143 cases will require 3,996 hours per year. Our staff complement provides 2,843 hours. We are using a number of volunteers and students during the year. Approximately 447 hours of volunteers and students during the year. Approximately 447 hours of service were provided in 1983. A deficit of 706 hours remain.

## MENTALLY RETARDED

This category includes any person with significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Service Level	Category	Amt. of Service	Avg. Monthly Caseload	Total Time (month)
1	Maintenance	½ hr/mo	115	58
2	Moderate	1 hr/mo	170	170
3	Intermediate	3 hrs/mo	13	39
4	Intensive	6 hrs/mo	25*	150

Description on

Level 1:	Individuals in out-of-county placement; clients who are state wards; require self-care skills; set unrealistic goals; desire independence; have minimal family contacts; respite care. The social worker attends annual teamings and monitors utilization.
Level 2:	Individuals in placement in county; client is developmentally disabled; lacks self-care skills; impulsive; lack of cooperation by client and/or family; appropriate family relationships. The social worker attends semi-annual teamings and may coordinate SILS services.
Level 3:	Individual requires initial assessment for residential placement; client is unable to accept disability; requires independent living skills training; peer relationships make the placement difficult; unrealistic goals; appropriate family relationship. The social worker makes referrals to group homes and may begin the commitment process.
Level 4:	Dual disability clients; inappropriate behavior; unaccepting of disability; lack of socialization and peer relationship skills; lack of employment ability due to behavior; paranoia; impulsive; lack of knowledge of sexuality; lack of ability

to understand directions; makes unrealistic goals. The social worker conducts vulnerable adult investigations and protection services.

Projections for 1985: To provide the above mentioned levels for an average of 323 cases will require 5,004 hours per year. Our staff complement provides 4,924 hours. (Includes position for waived services.)

\* Includes 15 cases projected for waived services.