

## HealthCorps Reader

### ***Part One: The Case Management Process***

Case management can be described as the process of assessing each client's biological, psychological and social needs and addressing those needs by linking him or her to existing community services and resources. Sometimes this occurs completely within the health center, while for other clients it can involve referral to outside specialists or to sources of free food and clothing.

Case management is an approach to care that considers *all* aspects of the family's situation. Most often, clinicians address the *biological* components of health. However, case management recognizes that well-being is also affected by a wide variety of systems: psychological, social, economic, environmental and so on. It works to promote health through each system. Although different types of practitioners can apply an overall case management approach or individual elements of that process, oftentimes specialized personnel known as *case managers* are trained and assigned to implement these coordination services with clients.

HealthCorps members serving health center clients may play a part in their center's case management system. This involvement can vary from handling a single step in the process (*for example*: calling agencies to locate a shelter for a homeless patient) to an on-going participation alongside a professional case manager.

Case managers work with each family to develop a plan that will help them achieve specified goals regarding their health. The plan most often includes action steps in the non-biological domains that impact health. An important part of this process is linking the family with other services, known as *referral*. While each situation is unique, the role of the case manager is not to fix all of the family's problems independently. Rather, in all interactions with clients, case managers employ strategies designed to help them develop the skills and confidence necessary to reach future goals *without the aid of*

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*the case manager.* The adage, “If you give a man a fish, he eats for a day; if you teach a man to fish, he eats for a lifetime,” truly reflects the philosophy of case management.

### *Elements of Case Management*

Although specific protocols and procedures differ among case management programs, most include the following elements:

- **Patient Identification.** Case management services are oftentimes designed to reach a target population. To ensure that a program works with its intended client population, it establishes particular criteria for participation. Common criteria include level of social support (*for example:* single mothers), economic status (families living at 125% of the poverty level), health condition (patients with asthma), environmental status (families living in homes with lead paint), or other special circumstance (family of a person who is terminally ill).
- **Patient Assessment.** Assessment is the initial step in working with a client. It involves identifying the client’s strengths, needs, and current status. It considers all the domains that affect the client’s health. Assessment presents an important opportunity to gather the information which will affect the case manager’s remaining work with that client. It is also used to begin establishing rapport with the client.
- **Goal Setting.** Goals are set based on the results of the assessment. Goals should be set collaboratively by the family and the case manager. These goals indicate what they anticipate to be the end product of their work together. Goals are established based both upon the family’s priorities and the mission of the case management program. Short- and long-term goals should be included and all should be readily attainable.

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- **Development and Implementation of an Action Plan.** The action plan can almost be thought of as a written contract between case manager and family. It identifies the steps each will take to meet the established goals. It should include a realistic timeline and clearly state who is responsible for each task. The case manager should use this process as a way to help the client see how to meet future goals (*for example: breaking a task into smaller, more manageable action steps and establishing a timeline for the completion of each action step*). The action plan is updated and revised throughout the case manager's work with the family; the clients should always be given an updated copy of the plan. To promote empowering relationships with clients, some case managers apply the following rule: *The case manager should not be responsible for completing more action steps than the client is responsible for completing.*
- **Patient Referrals.** A key piece of the action plan may be accessing additional services in a variety of fields. As such, it is important for case managers to become familiar with additional resources in the community in which they work. Oftentimes, case managers develop their own resource guides for reference as well as using those developed by others. Resource guides generally contain information about different types of services, which agency provides the service, and its name, address, hours of operation, eligibility requirements, etc. It is important for the case manager to track the outcomes of all referrals to ensure that clients receive the appropriate services.
- **Follow-up and Reassessment.** The goals of a client may change over time. It is important to monitor continuously the progress of the whole family and reassess whenever goals have been met or priorities have changed. In this phase, previously established goals may be altered or new goals may be established.

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### ***Part Two: Strength-based Assessments***

From customer satisfaction cards to the SATs to medical examinations, assessment is used in virtually all aspects of our lives. In case management, assessment is used to gain as full an understanding of the whole family's situation as possible. Information from the assessment is used to help develop goals and action steps. Many agencies have created their own forms and interview questions so they will collect standardized information during each assessment, no matter which department is doing it.

Good assessments have “bifocal vision.” Traditionally, assessments have focused solely on a client's problems or needs; this is known as a *deficit-oriented* approach. However, more recently, case managers are incorporating a *strength-based* approach into assessment as well. This approach focuses on the skills, attributes, and resources of each client which can be applied in reaching the family's goals. Initial action steps within the plan should encourage the client to utilize his/her skills, attributes, and resources. The traditional approach to assessment is useful in *determining a client's needs and goals* while the strength-based approach is critical to *developing the plan by which the client will meet the goals*.

The New York State Department of Health has outlined the following principles of strength-based assessment:

1. “Assessment is an ongoing process. Each family's goals, needs, and resources will change over time, and the family will share more with you as trust develops.”
2. Focus on the family's strengths, current situation, and future goals. When you help families evaluate past experiences and influences, focus on how these affect the family's *current* situation.”
3. “Effective assessment is family-driven, not agency-centered. The primary goal of assessment is to help families become healthier and more self-reliant. While agencies do need to collect information about their own effectiveness, this must not become more important than helping families assess their own needs.”

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4. “Assessment *with* families is much more effective than assessment *of* families or *for* families. Write down information with families in plain language and make sure they get a copy.”
5. “Collect only the information you really need and treat it with great care.”
6. “Assessment should be respectful and culturally appropriate to the family you are working with.”
7. “There are sometimes good reasons to use standardized assessments; collaborative agreements between agencies about assessment can make it easier for families to get services from these other agencies.”

All HealthCorps members serving inside a health center or one of its satellite delivery sites will witness many examples of case management work. The more our members understand what they see and how it fits into overall preventive and primary care, the better they will understand community health.