



Literature Review of Case Management – Basis for Further Research Executive Summary

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The Veterans Affairs Canada (VAC) Research Directorate undertook this literature review of Case Management (CM) to prepare itself to assist VAC with future work, as required.

The research questions were developed in consensus fashion by the authors prior to starting the review, and modified as the review progressed and the issues became clearer. The research questions were:

1. *What does published evidence say about the nature of Case Management?*
Specifically:
 - a. *What are definitions for Case Management?*
 - b. *What are the functions of Case Management?*
 - c. *How has Case Management been organized in various settings for various physical and mental health conditions?*
2. *What are potentially useful directions for further research in Case Management at VAC?*

This literature review was conducted collaboratively by a single health economist with long experience in provincial and federal government agencies, a physician with certification and 20 years of clinical experience in Family Medicine, and a researcher whose long VAC career included direct client contact as an Area Counsellor. We conducted a semi-systematic search for literature using PubMed, Google, and reference lists in various VAC and other reports. We included all types of literature for this preliminary review, including descriptive articles, expert single and consensus opinion statements, unpublished government reports, and peer-reviewed publications. Special attention was paid to peer-reviewed critical appraisals of the evidence where available. We tended to specifically exclude examples of CM implementation that did not directly apply to providing services or health care to Veterans.

This literature review was limited. Books were not searched systematically, and there are many textbooks on CM. There is a very large literature on the efficacy, safety and economic evaluation of CM for very specific settings and disorders, and we were not able to review that base in detail. Instead, we focussed on reviews. Evidence was informally graded using a standard approach. The synthesis was narrative.

As in other complex areas of modern health care system design, the literature on CM is a mix of individual or consensus description and expert opinion, backed by heterogeneous, incomplete scientific evidence. This is not different from the situation for comprehensive approaches to the management of disabilities (Thompson and MacLean 2009), except that in the case of CM evidence, even the expert opinion is somewhat fragmented.

Core functions of CM:

1. Collaborative development of an individualized case plan.
2. Monitoring client's progress against the case plan.
3. Planned disengagement.

There is, however, consensus on the core functions of CM: collaborative development of an individualized case plan, monitoring of the client's progress against the case plan, and planned disengagement.

Veterans Affairs Canada (VAC) has been providing CM to Veterans since the Veterans Charter implemented 60 years ago in the Second World War, when Medical Social Workers and Casualty Officers coordinated services for clients and their families. Canadian family physicians formalized concepts of CM during the 1960s to create the discipline of Family Medicine, administered by the College of Family Physicians of Canada. During the 1970s, CM practiced by nurses, social workers and other professions evolved to meet pressing needs of patients and institutions in acute care hospitals, mental health systems and workers' compensation.

There is no single model for CM, although all models share the core functions of identification, collaborative case manager/client relationship, needs assessment, collaborative development of a case plan, service facilitation, interdisciplinary collaboration, monitoring case plan, and disengagement. The case plan particularly distinguishes case management from other types of support. Specific implementations vary depending on the nature of the clientele, and the setting.

Although CM implementations commonly share case planning, monitoring and disengagement, they vary in other functions.

Case Management in health care is not the domain of any single health care profession. Nurses, social workers, occupational therapists, physicians and others practice various forms of case management. Some, like family physicians, have standards within their own profession for unique types of case management. Case Management is standardized in Canada and the US by national and regional associations that are becoming increasingly organized, with credentialing examinations.

CM has been used in a wide variety of settings, including hospitals, outpatient systems, workplaces, the military and Veterans administrations; and to assist persons dealing with a wide variety of physical and mental health conditions. There is wide expert consensus, and limited scientific evidence, supporting the opinion that in general, coordinated, collaborative client-centered CM can benefit

CM is widely thought to be an effective means for promoting the health of patients, caregivers and families facing bewildering challenges for a variety of social, physical, and mental health issues in a wide variety of settings.

patients/clients with complex health issues, their families and caregivers, and organizations providing services to them. Benefits to patients/clients may include improved access to quality care, improved satisfaction, and improved health, family and social outcomes. Benefits of CM may include improved client health and social outcomes, improved service delivery, improved resource consumption efficiencies, and optimum alignment of service delivery with the organization's goals.

There is limited literature on the economic evaluation of CM, and no systematic reviews of the quality of the evaluations could be found. Abstracts for nine articles found on PubMed with an analysis of costs were reviewed; only four were full economic evaluations i.e., analysis of costs and consequences. Many were simply cost descriptions. Evidence on the cost-effectiveness of case-management is mixed and mainly concentrated in one setting: serious mental health problems. The quality of the limited economic evaluations is unknown as a full quality review would need to be conducted.

Evidence on the cost-effectiveness of CM is mixed and mainly concentrated in one setting: serious mental health problems.

VAC's implementations of CM for modern programs as described in VPPM Volume 1 are consistent with the evidence found in this review. Although not called CM in 1945, the DVA (Department of Veterans Affairs) approach to rehabilitation for Second World War Veterans was also consistent with principles later recognized as modern CM.

This review provided us with a basis for suggesting three lines of potential future research: identifying individual clients likely to benefit from CM, management of CM programs using case mix (client groupings), and ways to contribute to a single treatment plan in collaboration with other agencies also providing CM to the same shared client/patient.

Further research:

1. Method to identify clients needing CM.
2. Use of case-mix (client groupings).
3. Toward a single treatment plan.