Current Trends Shaping Social Work Case Management

“Everything should be made as simple as possible, but no simpler.”
—Albert Einstein

Trends Influencing Social Work Case Management (SWCMG)

The North American health and human services organizations (HSOs) in which professionals are employed are usually stressful settings in which to work (Holosko, 2006). They are generally characterized by ongoing annual funding and budget cuts, more stringent eligibility criteria for service provision, shortened time frames for interventions, increased caseload numbers, numerous regulatory policies and procedures that are constantly being amended, less time for supervisors to consult with their front-line workers, and increased organizational settings in which to work and collaborate (Preston, 2010; Savaya, Gardner, & Stange, 2011). When changes in policies, budgets, or service provision happen, front-line workers, supervisors, and managers are forced to respond rapidly and adapt to them. Many human service workers feel that such changes seem to occur almost on a daily basis.

HSOs are profoundly influenced and shaped by a variety of trends that impact the where, when, and how SWCMG is practiced in this era of changing health care reform (Cesta, 2012). Almost a decade ago, Hoge, Huey, and O’Connell (2004) advocated
that behavioral health workforce personnel require an understanding of the diverse paradigms of various economic forces and trends that influence health care delivery, in order to be competent working in this area. Understanding such trends seem even more important today, given their frequency and occurrence. Sometimes such trends are clearly presented to HSO employees, and/or are time framed; for example, the agency will go paperless by July 15th. Other times, they and their implications are unclear to both the HSOs themselves and their employees; for example, next year’s state budget will have severe cuts to all state-funded mental health agencies. In such cases, these decisions are often made well beyond the agency walls—from “places above.” Thus, like many other employees, social work case managers (SWCMs) work in settings rife with overt organizational change and uncertainty, for example, fiscally, administratively, and policy-wise.

This chapter first identifies these various external trends and shows how they flow downward and eventually influence SWCMG practice. Second, it identifies selected practice transitions that SWCMs have to embrace to accommodate these trends. Finally, it concludes with a rationale for better SWCMG education and training across all social work curricula to meet the demands for employment in this burgeoning growth area. The trends described herein influence different health and human service professionals in various ways; however, this chapter emphasizes how they impact social worker practitioners in general, and SWCMs in particular. We preface this discussion by stating that the trends presented are certainly not the only ones impacting social workers and SWCMs, but ones that have been well cited in the extant literature in this field.

I. International Trends: Neoliberalism and Globalization

A. Neoliberalism

Somewhere, in the conceptual stratosphere above, social workers have often heard how the two topical buzz words neoliberalism and globalization have impacted social welfare policies and practices. Just how they have done this is less clear. Schriver (2013) noted that the worldwide trends of these rather nebulous concepts appear much better known outside of the United States than they are in America. However, given their prominence in shaping national social welfare policy in many developing and underdeveloped countries of the world, they merit attention in any discussion of macro trends influencing social work and SWCMG practice. It is important to first note (and distinguish) that the term liberalism is a political doctrine, and neoliberalism is an economic doctrine. Further, these very different concepts are often blurred because they both have the word liberal within them. Another point of conceptual fuzziness here is when liberalism gets applied to the field of economics, it refers to policies meant to encourage entrepreneurship by removing government controls and interference, which positions the term to more of a right-wing conservative notion than its truer liberal left-of-center political meaning. The concept of liberalism clearly embodies a political philosophy favoring individual freedom and liberty, equality, and capitalism (Hartz, 1955, as cited in Nilep, 2012), which has a long and deep effect in American history.
Turning to the concept of neoliberalism, neo means “new,” so this “new liberalism” was an economic shift from the previously described political concept above. Neoliberalism is about the freer movement of goods, resources, and enterprises in an effort to find cheaper labor and resources and, therefore, ultimately maximize profits and efficiencies (Holosko, 2015). The key assumptions or elements of neoliberalism described by Martinez and Garcia (1997) from the Corporate Watch include the following:

1. **The rule of the market**: The freedom for capital, goods, and services, where the market is “self-regulating.” It also includes the de-unionizing of labor forces, removal of financial regulations, and more freedom from state or government.

2. **Cutting public expenditures for social services**: This means reducing the so-called social safety net for the poor including health, human services, and education.

3. **Deregulation**: It involves the reduction of government regulation of anything that could diminish profits, including the protection of the environment and safety on the job.

4. **Privatization**: It includes selling state-owned enterprises, goods, and services to private investors including banks, key industries, railroads, toll highways, electricity, schools, and hospitals.

5. **Eliminating the concept of “public good” or “community”**: In short, these should be replaced with “individual responsibility,” at any cost.

As the concept relates to our post welfare states of its current citizen regimes, neoliberalism is also used to describe social welfare, welfare policy, ideology, or governmentality (Holosko & Barner, 2014; Larner, 2005; SUNY Levin Institute, 2013).

**B. Globalization**

A consensual definition of globalization is, “a process of interaction and integration among the people, companies, and governments of different nations, a process driven by international trade and investment, and aided by information technology” (Holosko, in press). This process has had profound effects on the environment, culture, economic development, prosperity, and human physical well-being in societies around the world (SUNY Levin Institute, 2013). Although neoliberalism and globalization were presented separately above, given their similar economic growth and trade imperative, in the past 15–20 years, these concepts have been inextricably braided (Holosko & Barner, 2014). In short, globalization is the reigning socio-historical re-configuration of social space, and neoliberalism is the policy approach to it. The term now used to promote their interrelationship is neoliberal globalization (Scholte, 2005).

When examining the literature about the so-called pluses or minuses of neoliberal globalization over time, the minuses far outweigh the pluses. This is particularly true in the area of social welfare, as in the past 25 years we have seen: more poverty worldwide than ever before, greater discrepancies between economic and social groups, more income inequality between the rich and poor, less human security and human rights, less social justice, poorer environmental health, and poorer safety and
employment policies (SUNY Levin Institute, 2013). However, during this same time, there have been some noteworthy gains made in commerce, trade, finance, investment, technology, international law, military alliances, transportation, banking, and energy (Holosko & Barner, 2014). But, a closer look at who has made these latter gains clearly reveals that it is almost always the wealthier and dominant countries and corporations of the world, from which observers have now coined the phrase economic colonialism (Schriver, 2013). Unfortunately, although such economic concerns are important, they are not the life blood of social work practice, and/or social welfare policies. In sum, it is not a stretch to say that overall, social welfare and its clients have not fared well at all, under the umbrella of neoliberal globalization.

II. National and Local Trends

The demand for social workers in general, and SWCMs specifically, will increase considerably in the next 10 years in America. In the recent U.S. Department of Labor, BLS Occupational Outlook Handbook, 2012–13 Edition, Social Workers (www.bls.gov/ooh/Community-and-Social-Service/Social-workers.htm#tab-6), it is projected that the employment of social workers is expected to grow by 25% from 2012 to 2020, faster than the national average for all occupations. It is also noted that this will be apparent in the areas of a) health care, expected to grow by 34%, b) mental health and substance abuse services by 31%, and c) social and family services by 20%.

In an effort to be proactive to these trends looming on the horizon, as they merge with the onset of The Affordable Care Act in September 2013, the Council on Social Work Education (CSWE) hosted a White House de-briefing in Washington, DC, titled “Addressing the Social Determinants of Health in a New Era: The Role of Social Work Education.”

This discussion focused on preparing the next generation of social work practitioners for the new paradigm in health professional education and collaborative practice to meet the needs of all Americans. The goal of the event was to come away with a shared understanding of the future of health care in the United States, broadly defined, and identification of a path forward for social work education in this new era. (CSWE, 2013, p. 1)

In addition to other featured panels on shifting demographics, mental health needs and building capacity, one titled “New Expectations for Health Care” addressed what the new era of health care looks like with respect to integrated care, inter-professional health care teams, and consideration of social determinants of health (CSWE, 2013, p. 4). In the past decade or so, two emergent trends in SWCMG have evolved, and they seemed well positioned to respond to this national imperative. These include a) re-engineering the goodness-of-fit between social work and case management, and b) promoting self-advocacy in case management planning and intervention.
A. The Goodness-of-Fit Between Social Work and Case Management

Since the inception of social work practice in North America, whether our frontline workers were called “friendly visitors,” “settlement house workers,” “care givers,” “case workers,” “social case workers,” “social workers,” or “case managers,” one of the key and long standing attributes of our profession has been its ability to adapt, modify, and re-engineer itself across a broad range of fields of practice, vulnerable populations, and settings. Indeed, it has been argued that our profession’s malleability legacy has been a unique part of its historical growth since its inception (Lubove, 1969). Since the 1900s onward in North America, the field of case management has had a parallel professional trajectory in adapting, altering, modifying, educating, and training workers, as it evolved from community settings, to hospital settings, to mental health settings, and finally to social welfare institutions of care—all of which are still the domains where SWCMG is currently primarily practiced. The profession of social work has evolved by literally living its hallmark adage of “always take the client s/he is at,” and in turn, help them move to a better place in their lives. This pervasive person-centered mission transcends all of both social work and SWCMG practice as we know it today.

Beneath this overarching mission, the profession has anchored itself in various practice approaches, core values, and a tried and true intervention model called the problem-solving approach for practice. Taken together, these collectively serve as the rationale why social work and case management are indeed such an appropriate goodness-of-fit. Some of the other noted practice perspectives the profession has used (and still uses today) include social case work, person-in-environment, ecological, ecosystems, bio-psycho-social, task-centered practice, feminist, solution-focused brief therapy, systematic family therapy, and more recently (in the last 20 years or so) strengths-based, social justice, resource procurement, barrier identification and removal, environmental, and neuroscience. Underlying these varying perspectives are a set of humane core values from which we have never wavered. These include self-determinism, autonomy, respect, genuineness, individuation, service, dignity and worth of individuals, social change, importance of human relationships, social and economic justice, integrity and competence. Our professional code of ethics firmly holds all of these values dearly, and for those of us in the profession, they help explain how we do, and what we do to others.

As indicated, although it has been often deemed a solution-focused approach, the overarching model currently used to describe our day-to-day person-centered work with clients is more frequently known as the problem-solving approach. This minimally includes the sequential steps of engagement; assessment; planning and contracting; action/doing, or intervention; monitoring and evaluation; and termination. In sum, the above noted practice perspectives, core analyzing values and scaffolding person-centered problem-solving model of social work practice, coupled with the profession’s unique ability to re-engineer itself, has had applications in all fields of health and human service practice. These have also stead the growth of the profession very well and, by default, have stead those social workers who practice case management, very well also.
B. Promoting Self-Advocacy in SWCMG

Case Planning and Intervention

One of the more pervasive trends clearly emergent in the past decade in North American SWCMG is the shifting of care responsibilities to the actual “person-in-care.” In most health and mental health settings, these “persons” are typically called “patients,” in elderly care settings they are often called “residents,” in criminal justice systems they are “inmates,” and in social welfare service organizations, they are normally called “clients.” Thus, it is the organizational domain who labels the “persons-in-care” who receive case management services.

Health care organizations generally, and nurses specifically who work within them, promote, provide, and drive the entire case management field more so than any other profession. As one cognate professional in the health care arena, SWCMs are far fewer in number than their nurse case management counterparts and work typically in collaboration with them to provide various case management services. In some settings, like hospitals, SWCMs provide a range of complementary case management services with nurses normally attached to a particular unit such as an emergency room (Fusenig, 2012). They also provide more traditional case management tasks and functions in various other units of the hospital— for example, acute care, aging services, children services, etc.—such as assessment, discharge planning, in their roles as members of the overall social work department.

Given the prominence of case management in health care in North America, as well as the large disproportionate body of literature published on it in this area, social work looks to SWCMG in health care for leadership in the area of trends in other areas of case management. Typically, the international and national external trends previously noted in this chapter trickle down through health care first, followed by mental health, and then eventually family and social service agencies. These three occupational areas currently employ the largest number of social workers who are typically called “case managers” in their respective job titles.

As indicated (in the title of this subsection on national trends), the issue of self-advocacy in health care planning is a major concern that SWCMs deal with on a daily basis. In North America, Canada refers to this normally as care coordination, and in the United States, it is usually referred to as patient advocacy. This approach is one where the patient is a full and active participant in his or her care planning and intervention decisions. Thus, the ownership of caring for the person-in-care, shifts from care providers, to care providers and their patients (Bodenheimer & Abramowitz, 2010; British Columbia Ministry of Health, 2011). As such, patients are proactively educated and trained about how to care for themselves when they receive case management services. Consequently, SWCMs encourage and facilitate their patients to move from a passive, to a much more assertive and active role in their own care. In this model, SWCMs, in full partnerships with their patients assess their needs, determine their service eligibility, procure and negotiate resources, develop plans for care, develop treatment goals, initiate interventions needed, and in doing so, they educate and train patients about a) what their formal and informal support systems are; b) what barriers exist for care; c) what care arrangements the patient is responsible
for; d) ways to empower patients to affect their self-care; and then, e) follow-up and evaluate the agreed-upon care-planning arrangements and intervention activities. In addition, the entire process is time-framed, both output and outcome driven, and transparent.

Further, this model promotes self-direction and personal management, self-efficacy, a personal investment in overall care planning, self-actualization, and more personal accountability. Empirical studies conducted on this proactive patient-empowered approach to case management practice have shown better illness prognosis, more positive health outcomes, greater patient satisfaction, and shorter time frames for achieving stability, and recovery benchmarks (Anderson & Funnell, 2010; Fleming-Castaldy, 2010; Holman & Lorig, 2000; Kendrick, Petty, Bezanson, & Jones, 2006; Leske, Strodl, & Hou, 2012). This groundswell national trend case management trend is not only prominent in health care where fee-for-service and eligibility criteria direct patients through various systems of care, but also in other settings where SWCMG is practiced.

The two main models where SWCMG is practiced today were astutely first described by Rose and Moore (1995) as “client driven” and “provider driven.” The former is the model that most SWCMs are more comfortable with; as normally, in this model, client needs are identified and accessed mutually, treatment goals are developed, links to formal and informal services are identified, and the monitoring of outcomes are done in full partnership with client input into this process. The essence of this SWCMG-client work focuses on identifying client strengths and obstacles to the obtainment of goals, developing social networks, freeing the client from clinical judgments and contempt, and assessing the role of each service system intervention as either a support or obstacle (pp. 228–229).

Conversely, the so-called provider-driven models are cost and eligibility driven, as restrictive and narrow parameters are set on the decisions made in the entire case management process, where a limited (by resources and options) menu of fee-for-service choices are offered to clients. The SWCM-client work in this model focuses on identifying problems, making resources and referrals for services, ensuring client adherence and compliance to treatment plans, and monitoring time-framed outputs and outcomes (Rose & Moore, 1995, p. 229). As previously noted, this model is more closely aligned to health care, but in actual practice many SWCMs are employed in North American settings that have features of both models.

The above-mentioned international trends, in turn, trickle down to influence national and state trends, then eventually impact local trends, where SWCMs practice. Thus, how they actually shape day-to-day practice where social workers and SWCMs are employed will be presented.

III. How Trends Shape Social Work and SCWM Practice

Table 1.1 distills four selected trends at the local levels of social work and SWCMG practice, and not only describes them in terms of their impact, but candidly offers the “stories behind the trends.”
PART I: TRENDS, HISTORY, SOCIAL WORK CASE MANAGEMENT MODEL, AND PRACTICE COMPETENCIES

Table 1.1 Four Selected Neoliberal Globalization Trends Influencing Social Work Practice

<table>
<thead>
<tr>
<th>Selected Trends</th>
<th>The ‘Stories Behind the Trends’</th>
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| 1. Increase in Service Demands ↑ Decrease Funding ↓  | 1. Do More with Less  
2. Think Smarter                                                                        |
| 2. Community 'Problem Reconfiguration’                | 1. Communities Lag Behind the Concepts  
2. Matching Mandates to Problems                                                             |
| 3. Integrative Approaches to Service Delivery        | 1. Define Partners and Stakeholders  
2. Develop Joint Agreements                                                                |
| 4. 'Era of Legitimacy’                                | 1. Evaluation of Program and Services  
2. Interventions → Outputs → Outcomes                                                        |

**Trend 1: Increase in Service Demands ↑ Decrease Funding ↓**

Each day, more and more vulnerable individuals require more and more social welfare services all over the world (Feit & Holosko, 2013). Social welfare defined broadly here, is taken to include education, health, housing, and social services. Although “real spending” as a percentage of GDP reflected in constant dollars (and adjusted for inflation) has grown in North America, per capita spending for social welfare (actual dollars per person) has not significantly changed in the past 25 years or so (Holosko & Barner, 2014). This is particularly true for the two most vulnerable groups in our society, the very young and very old (Pati, Keren, Alessandrini, & Schwarz, 2004).

At the organizational level, HSOs are a) often compete fiercely for limited funds; b) are forced to find creative ways to offset their annual escalating costs through revenue sharing, limiting eligibility criteria, re-prioritization and re-structuring their organization’s mandate; c) use more and more non-professional, and/or volunteer staff; d) borrow money against their limited budgets; and e) actively seek out more funding avenues, for example, external grants, private donations, cost-shared arrangements, and contractual services (Holosko & Barner, 2014). Heller (2006) referred to these responses as seeking more “fiscal space,” or finding additional resources to service clients in these troubled neoliberal financial times.

The stories behind this trend are rather bleak as with such limited resources, and in our altruistic efforts to do our allegedly important mission-driven and client-centred work, HSOs are fiscally and politically scrambling just trying to survive—let alone thrive, in today’s climate. Indeed, SWCMs (like other human service employees) are constantly under pressure to do more with less, as their caseloads and waiting lists for services increase daily. As previously indicated, financial uncertainty is both ubiquitous and pervasive in most HSOs, and there isn’t a supervisor or administrator in any HSO who would not be elated if their annual funding was re-approved next year with a “zero percent increase”—as they have come to realize that there could be far worse scenarios.
This trend, impacting the domain in which SWCMs work is conducted, creates challenges for all human service workers, as if they continue to do too much more—with no complementary supports or resources, they may find themselves compromising the very services they are mandated and ethically bound to deliver to clients (Allen & Smith, 2008; Holosko & Barner, 2014). Finally, SWCMs can only be asked to “think smarter” and “be more efficient” a finite number of times, or the proverbial double-edged sword of quantity vs. quality is sure to cut someone in an injurious way—and it’s most likely to be our clients. We contend that this first trend, although intimately related to the others noted in Table 1.1, holds significantly more gravity than do the other three. It is also one that SWCMs are very aware of, given that it affects all areas of their direct and indirect practice with vulnerable clients on a daily basis.

**Trend 2: Community “Problem Re-configuration”**

There has been a decided shift in the current devolution-revolution of health and human services to developing social welfare programs, interventions and services in communities, not from a population or demographic imperative, but from a problem re-configuration one. Here, a community’s problems are prioritized, based on the so-called problems of individuals in the community. So, depending on “the problems that the community has,” and its existing infrastructures—if one is fortunate enough to end up with a problem that the particular community “has identified”—care can be accessed. Conversely, if one’s problems do not match up with “the community problems”—clients must travel (if they can) to usually adjacent communities to receive care (Feit & Holosko, 2013). For example, in Canada’s and Sweden’s universal health care systems, smaller towns and cities cannot afford highly specialized health care for all citizens. As a result, many citizens needing such care are accustomed to driving, or being airlifted to proximal communities that have the specialized care that they require and have come to expect (Holosko, 1997).

The stories behind this reality are noted in Table 1.1. First, communities clearly lag behind this concept, and they have difficulties matching their infrastructures and mandates to the ever-changing “problems of the community.” To exemplify the stories behind this trend, Brown and Stevens (2006) studied seven U.S. communities who aimed to expand health coverage to the uninsured and improve their care (the main current political agenda of President Obama). Funded by the Robert Wood Johnson Foundation’s *Communities in Charge* (CIC) program, when these communities (with identified community problems) were evaluated, they concluded that:

> Despite solid leadership and carefully crafted plans, political, economic, and organizational obstacles precluded much expansion of coverage and constrained reforms . . . CIC’s record offers little evidence that communities are better equipped than are other sectors of U.S. society to solve the problems of un-insurance. (p. W150)

SWCMs, by virtue of how they practice, become acutely aware of the limited resources available to clients in their own communities. This forces them by default, to expand on their definition of just what “local community care” is—to a more expansive one, involving a greater geographic area beyond the local community.
This in turn, presents a new set of resource challenges such as networking with these new service providers, new waitlist protocols, service availability, access to services, cost, formal and informal supports for clients in these new geographic areas, referrals, and transportation for services.

**Trend 3: Integrative Approaches to Service Delivery**

Due to the current trends of devolution and fiscal cutbacks for North American HSOs, services and providers have become collaboratively bundled together with multiple agencies offering defined systems of care in their respective communities (Cook, Michener, Lyn, Lobach, & Johnson, 2010). These are often referred to as cross-sectional collaborations—networks, alliances, or partnerships among public, secular and faith-based non-profits, and for-profit organizations. They either consist of distinct organizations that develop relationships with each other to meet client needs called “self-organizing networks.” Or, they are community organizations sub-contracted with a lead organization, which is expected to create a mandated community-based network of service providers (Provan & Milward, 1995; Whelan, 2011). The latter (lead organization model) is the more preferred approach as frankly, it is cheaper. But ideally, both arrangements are expected to yield the benefits of increased efficiency, innovation, local adaptation, increased flexibility, and enhanced community ties (Graddy & Chen, 2006, p. 534).

This idea is certainly tenable and required in today’s reality, but the concept appears to be ahead of the community’s ability to implement it. The previously noted proverbial “clouds of uncertainty” about integrative service approaches hover large over issues of costs, organizational, programmatic, and community influences, democratic and consensual accountability, efficiency and effectiveness, integrative models that are viable and ones that are not, organizational and community care constraints and contingencies, community capacities, access, outcomes, policy considerations, and network size and scope (Bryson, Crosby, & Stone, 2006; Knitzer & Cooper, 2006). Despite such uncertainties, HSOs continue to move forward with this seemingly altruistic community-spirited ideal, which has profound implications for how SWCMs provide services to their clients.

In addition, the neoliberal deficit reduction strategies of federal, state, and local governments has led to a resurgence of interest in community collaboration (Foreman Kready, 2011). Increasingly, mandates for collaboration are linked to conditions of funding. As governments mandate collaborative networks as implementation mechanisms for integrating social welfare services, empirical studies about how inter-organizational collaboration is implemented among community partners is an emerging research, policy, and practice area (Babiak, 2009; Bryson, Crosby & Stone, 2006; Sytch, Tatarynowicz, & Gulati, 2012).

Many, social workers and SWCMs are very mindful of some of the more important issues about the real “stories behind the story of collaboration” (Holosko, 2009). Here are a few:

1. **Funding issues require collaboration:** Regardless of the “will” to collaborate, such partnerships are tied to funding. Those HSOs who do so will thrive, and those who do not will
inevitably wither away. Thus, developing relationships with partners in the community however strained, is integral to local organizational survival.

2. Voluntary vs. mandatory collaboration: Although different joint agreements are voluntary and some are mandatory, the nature of the collaborative relationship transcends this distinction (Dunlop & Holosko, 2004). This means that agencies collaborate to ensure funding, and typically will do anything they can, to make the collaborative relationship work.

3. All communities are not created equal: Communities vary greatly in their demographics, organizational relationships, service networks, pre-existing partnerships, resources and infrastructures, and collaborations seem to magnify such inequalities. Thus, some communities are able to develop more effective collaboration networks than others.

4. Evaluation complexities: Evaluating collaborative initiatives has been challenging to say the least, as these initiatives are typically multi-site, multi-level, with different programs/goals/objectives/costs/outcomes/services/stakeholders, etc. The assumption put forward here is that complex community-based collaborations are more efficient than singular service delivery models. However, this has never been empirically determined or validated (Holosko & Feit, 2006).

5. Collaborations are more likely to succeed when they have legitimacy: Finally, Human and Provan (2000) cited three necessary conditions for collaborative network survival: 1) legitimacy of the network as a form that can attract internal and external supports, 2) legitimacy of the network as an entity responsible to both insiders and outsiders, and 3) legitimacy of the network as an interaction that builds trust among members to freely communicate with one another. Although somewhat dated, these conditions hold true today.

**Trend 4: Era of Legitimacy**

Never before in our North American social welfare history has evaluation and its focus on outcomes been “part and parcel” of the mandated delivery of our intervention’s programs and services. Indeed, we are no longer on the frontier of program and practice evaluation activity, but are in the midst of a groundswell of such activities becoming mandated in federal and state social welfare initiatives, programs, and services. In turn, public scrutiny for the financing and efficiency of outcomes is more apparent than it ever was before. We have evolved from offering social welfare programs directed by the rather noble motives of altruism and case wisdom, or “a need for such services,” to much more cost legitimizing ways of providing health and social services. These include the empirical testing of all interventions; developing more empirically defined protocols for our interventions; increasing treatment fidelity, developing pilot projects to justify larger initiatives; ensuring interventions are tied to defined frameworks (i.e., logic models) and outcomes; developing organizational and community capacities to ensure success of interventions; funding initiatives with the assurance of self-sustainability over a shorter time period; ensuring that funded social welfare initiatives include timely best, and/or promising practices; and ensuring that funded programs/services are both effective and efficient.

Presently, SWCMG requires not just a traditional focus on inputs and outputs, but also on outcomes and their sustainable impacts (W. K. Kellogg Foundation [2006] website reference for the program logic model framework: http://www.wkkf.org/
knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx). And these must be assessed empirically with a view to what it costs to provide such interventions. Clements, Chianca, and Sasaki (2008) said it more succinctly: “evaluations should estimate the total impacts that can be attributed to an intervention and also estimate the intervention’s cost effectiveness. . . . Also, evaluations of this nature are likely to be more helpful for program managers” (p. 196). Given that the current SWCMG model is now being driven by costs, it appears that soon, the cost benefit or cost effectiveness of all social work interventions will need to be tabled as a bona fide agenda for all case management services.

In conclusion here, with The Affordable Care Act currently unfolding in the United States, the issue of providing local systems of care models that are cost effective are paramount to this initiative. Given our knowledge of how formal and informal systems are linked to clients with resources and services, social workers and SWCMs are in ideal positions to take a leadership role in the delivery of the next generation of health care in America. This sub-section provided the context for how community trends shape this reality. Hopefully, having better awareness and thinking out of the agency box, which SWCMs routinely do, in order to administer timely care to their clients, will become the norm for all health care professionals, in the near (and very soon) future.

IV. Practice Transformations

Chapter 1 briefly outlined the history of social work practice in North America, and the more elaborate history of SWCMG practice. As was noted, the so-called manage care movement that predominated the health and mental health institutions in the 1970s and spawned fee-for-service insurance providers and HMOs, cost efficiency measures, the expansion of private hospitals, and the growing specialization of tasks and functions required social workers to practice effectively in such settings. Since then, SWCMG became re-defined iteratively through both pieces of enacted federal legislation significantly including: Community Mental Health Centers Act (1963), The Deficit Reduction Act (1984), The Americans with Disability Act (1990), Personal Responsibility and Work Opportunity Reconciliation Act (1996), Mental Health Services Act (2004, 2009), and recently The Affordable Care Act of (2010), as well as numerous state-wide policy and best practice changes and their various revisions over time.

In addition to the previously mentioned flexibility of the social work profession to continually adapt in its professional survival, the profession with the advent of case management as we know it today has had to make some practice modifications that have helped to solidify its prominence in SWCMG services overall—and many of these adaptations have many been made in the “trending domain” area of case management practice—that being health care.

After interviewing 12 SWCMs currently practicing in this area in the U.S. and Canada (for this text), it became clear that social workers have had to constantly modify, adapt, learn, re-learn and transform their practice thinking, in order to be both current and relevant in practicing effectively as SWCMs in today’s reality. Thus, we present an overarching Table 1.2 delineating 10 such transformations. We realize that these are not the only SWCMG transformations necessary, but are ones that currently
fall directly out of the noted preceding trends, the literature on this subject and ones conveyed to us by the 12 SWCMs we interviewed. Indeed, our profession seems to role model the very resiliency we have some to expect from many of our clients.

As indicated in Table 1.2, these transformations are localized where the actual faces of our clients, meet the faces of SWCMs. Thus, we also wanted to illustrate a clinical/direct or micro practice focus to these transformations, as others have used more meso and macro lenses to examine the impact of trends in other practice areas (Holosko & Barner, 2014).

**Individual → Problem of Individual**

Although social work’s core humanistic and altruistic values involve positioning the person above all other considerations, the first trend repositions a person with a problem, to the problem(s) of a person. Historically, since the history of case management (CMG) is driven by health care more so than human service organizations, the latter approximates what we have termed the so-called medical model. This is defined as, “the traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western world; that focuses on the defect or dysfunction” (Stedman’s Medical Dictionary for the Health Professions and Nursing, 2012).

Although the problems of individuals usually drive SWCMG, this is not to say that social workers cannot, and/or should not maintain a strong professional commitment to providing person-focused and not necessarily patient-focused care (Hsieh, 2006; Kitwood, 1997; Parker, 2001; Starfield 2011). Indeed, SWCMs learn to work “within the contradictions” of their existing agencies and settings, by keeping the person foremost, in any discussion of the problem. In many health care settings, SWCMs have to constantly remind clients, families, colleagues, and other health professionals of their
core person-centered values and how they are unique to social work, how they can complement and add value to the existing care system, and more importantly, how they can benefit clients in their existing care systems. This is where tact, diplomacy, deft and selective communication skills, values and knowledge are used simultaneously with each client, not patient (as agencies may force us to use this label), we see. As stated poignantly by Parker (2001):

> It is crucial in contemporary social and healthcare to retain a clean sense of the person with whom we are working with at any point in time. We must also keep firmly fixed in view what we are working to achieve and what the impact of the illness is on that particular system and network of individuals. . . . A shift in culture and thinking does not deny the importance of medical advance but adds a holistic and human element that brings the person to center stage. (p. 341)

So despite this paradigm shift, SWCMs work thoughtfully and deliberately to continue to “keep the light always shining on the person,” and not their problem foremost. Indeed, this is a defining professional characteristic of how social workers practice CM, different than other cognate disciplines.

**Client → Consumer/Customer**

Trend 2 in Table 1.2 illustrates the transition for SWCMs to shift from a client to a customer, or consumer focus. Any way you look at this, it smacks of a corporate/business model, where somehow people have exchanged money by cash or insurance, and they received a product. Although this formula seems simple, it presents some real challenges for SWCMs who interact with vulnerable individuals on their caseloads each day.

The first is that we have been trained in BSW and MSW programs that these are our clients, not customers. Second, our profession acknowledges that many of the activities that we routinely assist clients with, are impossible to have a monetary or discrete cost asset value. These are things like timely information offered to clients to make better informed decisions; empowering individuals; assisting clients to be less angry, less violent, less anxious, less depressed, less dependent; or conversely, more thoughtful, more goal oriented, more supportive of friends and family, more spiritual, more educated, more employable—and the list goes on here. So how would one be able to evaluate our effectiveness on one, two or three of these things, and/or how would one go about doing that (Hsieh, 2006)? Second, as consumers (the other half of the term), what did they actually “consume” during their process of therapeutic engagement with SWCMs?

So what is the resolve for SWCMs who are being nudged to move in this direction? Our contention is that this is similar to “working within the contradictions” of our organizations mentioned earlier. Thus, we must strive to continue to re-frame in our hearts and minds that these are our clients foremost—people in need, who require timely and humanistic services, and whatever the organization or agency calls or labels them, and as long as these labels do not inhibit our service or dismiss/minimize our clients in anyway—as they say in street lingo—we need to learn to “live with it.”
In an effort to assess and clarify how health care consumers perceived of themselves, West (2013) stated:

The consumer metaphor fits imperfectly with the healthcare system and with the experiences of healthcare users, and carries with it a host of associations that shape U.S. healthcare policy debates in particular ways. If ideological discourse is created in an attempt to smooth over contradictions and uncomfortable truths, then we ought to examine its limits, as users either adopt a consumer discourse about health in making sense of their own experiences and perspectives on the healthcare system or identify its gaps and disjunctions. (p. 300)

**Person-in-Environment (PIE) → Person-in-Care-in-Environment (PICIE)**

Trend 3 shifts one of our traditional cornerstones of social work practice (Bartlett, 1970; Boehm, 1954). Recognized as the main domain and providence of social work practice, the primary focus of person-in-environment (PIE) is the interaction(s) between the person and his or her environment that encapsulates a more holistic understanding of the client and his or her problem in the context of their environment (Ramsay, n.d.).

PIE has indeed been the leading paradigm of social work practice, but with the advent of CM, our overt care-centered focus pushes the original model to envelop broader environmental and contextual considerations throughout each phase of SWCMG. Indeed, we concur that the existing PIE model even in traditional non-case management settings (not health or mental health), needs expansion to better understand: how evidence-based practice may be used more effectively within it (Simmons, 2012); how psychosocial aspects may be better addressed within it; how various levels of the environment may be more understood from the multi- and interrelated dimensions in a more integrative approach (Ashford & LeCroy, 2010); how psychosocial functioning and timely psychotherapy can be better understood from the broader environment (Saari, 2002); and, how the environment could be better expanded to include its ecological context for social workers concerned about sustainability (Jones, 2008).

The SWCMG Person-in-Care-in-Environment (PICIE) model is one that considers many levels of care and environmental supports that any client has simultaneously. For example, during the assessment step, appraisals of psychosocial variables, biological variables, mental and environmental health variables, capacity/capabilities/decision-making variables, as well as motivation to want help, are considered and carefully appraised by SWCMs. Obviously, in health care settings these are more routinely assessed by using additional standardized tests and protocols, inventories, scales, etc. However, outside of traditional health care settings, considerations of many of these various assessment criteria are also appraised by skilful SWCMs, without directed or regulatory requirements, having minimal training, or by using only tests or time-framed protocols. As such, much of this is learned “on-the-job,” and involves the judicious use of accrued “case wisdom” and timely supervision.

The PICIE model also expands the client’s environment appraisal to move beyond the immediate environment (i.e., household members, family and friends) to the
secondary environment (i.e., formal and informal care systems in the environment, neighbors, work, social media help and the internet, etc.). Careful assessment of these expanded environments and how they relate to the care needs of clients requiring CMG services is the norm in SWCMG practice.

**Care System → System of Care**

Trend 4 shifts the traditional focus of SWCMG from a care system, to a system of care. The system of care movement has been in a process of development in both health and social welfare care of children and their families, adults, and the elderly. Table 1.3 shows how system of care reform efforts interface with SWCMs in our “communities of care.”

As indicated in Table 1.3, such reform efforts shape the context for how we provide SWCMG services. We anticipate that these reforms will see more changes as The Affordable Care Act unfolds more completely in the United States in the next few years. But referring back to sub-section one of this chapter, “context is everything,” and as

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<tr>
<td>Fragmented Services</td>
<td>Coordinated Service Delivery</td>
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<tr>
<td>Categorical Programs/Funding</td>
<td>Multidisciplinary Teams/Blended Resources</td>
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<td>Limited Service Availability</td>
<td>Comprehensive Services</td>
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<tr>
<td>Crisis-Oriented Approach</td>
<td>Focus on Available Care Responsive Services</td>
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<td>People Out-of-Home</td>
<td>People Within Home as Long as Possible</td>
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<td>Client Care</td>
<td>Community-Based Care</td>
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<tr>
<td>Creation of “Dependency”</td>
<td>Creation of “Self-Help” and Active Participation</td>
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<td>Client-Only Focus</td>
<td>Client and Supports as Focus</td>
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<td>Needs/Deficits Assessments</td>
<td>Strengths-Based Assessments</td>
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<td>Families as “Problems”</td>
<td>Families as “Partners” and Therapeutic Services</td>
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<td>Cultural Blindness</td>
<td>Cultural Competence</td>
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<td>Highly Professionalized</td>
<td>Formal, Informal, and Natural Support Coordination</td>
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<td>Client Must “Fit” Services</td>
<td>Individualized Approach for Eligible Services</td>
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<td>Input-Focused Accountability</td>
<td>Outcome-/Results-Oriented Accountability</td>
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<td>Clients With Problems</td>
<td>Clients as Partners in Solving Problems</td>
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*Table 1.3* Characteristics of Systems of Care as Systems Reform Initiatives

we continue to practice daily with clouds of fiscal uncertainty, such trends may change as governments change, policies change, and as political parties change. This is the work we have chosen, but now we at least have more enlightenment about what and how these trends change iteratively and shape our SWCMG practice daily.

**People Changing → People Processing and People Sustaining**

Trend 5 offers another interesting paradigm shift for SWCMs to consider, that being moving from a traditional “people-changing” paradigm, to a “people-processing” and “people-sustaining” one. The origin of this term comes from Y. Hasenfeld (1983) who encouraged our profession to not only look at the client as the unit of analysis, but hover above the client to obtain another view, that being the organization and its community domain as the unit of analysis. Hasenfeld (1983) developed the notion of exchange relationships between organizations as being the interactive lifeblood of any health and human service organization. All SWCMs know that as they shepherd, coordinate, navigate, negotiate, broker, mediate, collaborate, etc., with more clients daily in their systems of care, that organizational exchanges are essential to the overall CMG process. Relationships with partners and collateral agencies including various contacts/support people, decision-making people, authority figures, care providers, etc., are how most SWCMs spend most of their hours each day. Indeed, although client access is an important occupational concern for all CMG (Hsieh, 2006), most SWCMs spend more than 85% of their time tending to the various exchange relationships with a host of individuals in the communities of care in which they work, or they cannot do their jobs effectively (personal communication, D. Holosko, 2014).

SWCMs like other SWs are well aware that for accountability purposes “body count data” prevails—or more simply the more people you see, the more funding you receive (Holosko, Bulcke, & Feit, 1997). So a constant and increased admission stream of clients is always needed or funding will be curtailed, for the most part. However true, this tends to present us as being overly concerned about just being people-processing types only, which is not true. It also, by default, infers that a) somehow people processing is not a nice term or notion, and b) the other terms people changing and people sustaining are more humane (in an odd sort of way).

SWCMs who adhere strongly to their core set of professional values see all of these three from a decided strengths-based perspective. For if we don’t move clients through their systems of care, we would be negligent in actually getting them care. Second, we have lost the idealized notion that all clients will change, and will change “for the better” after we intervene with them. That simply is not true. Case wisdom reminds us that some clients resist change, placate change, deny change, fake change, fear change, and/or oppose those who want them to change. We have also realized that many clients are stuck in negative places that they choose to be stuck in, as it is “familiar territory” to them. Others are very content to be stuck in what Seligman (1968) referred to as “learned helplessness,” where they simply bumble along with no resolve to change anything about themselves at all. In short here, SWCMs do not see people processing as anything more than a positive step for many clients.
Finally, for many clients “no change” or “people sustaining” are very positive. Being stable on psychiatric medications, having a positive and enduring support system, being semi-independent, being motivated to be active partners in their care without knowing full well what is involved in that partnership, are very sustainable examples of care that help many clients. In short, SWCMs come to view people processing, changing, and/or sustaining as “part-and-parcel” of the essence of effective practice as when these are anchored in our core values, all can be framed from a decided strengths-based perspective.

**Programmed Decision Making → Shared Decision Making**

In every client–worker relationship, is a perception that there is a power dependency dynamic, where the worker holds the ultimate authority and the client has limited or no power (Lupton, 2011). As indicated in the first sub-section of this chapter on trends and their influence, a fundamental paradigm shift in CMG in general, and in SWCMG in particular, which is “front and center” in this field, is that clients must become full partners in this relationship from the onset and share in the decision making for their treatment plan. The skilled SWCMG does not shift any (of his or her) authority/work/tasks/responsibilities to the client, but shares the important responsibility with the client to first “own their problem.” Then, the SWCMG and client can more readily become proactively involved in a variety of necessary ongoing shared decisions to affect their meaningful client-centered care plan of action.

The current literature on user involvement in health, social service care, and planning rests clearly on the premise that user involvement, education, and shared decision making is a good and necessary thing to promote in all helping relationships, and it is likely to result in more positive impacts (Rhodes, 2012, p. 187). In this regard, a flexible communication strategy is required by all SWCMs to meet the needs of different client populations in many different contexts, as the first step to developing a genuine collaboration in an open and honest relationship. Thus, it is an essential pre-requisite for clients and SWCMs to work together to make all-important medical decisions (Minogue et al., 2009; Morgan & Jones, 2009). In the medical literature, it is well documented that shared decision making has resulted in positive outcomes such as lower health care use, lower health care costs, and fewer hospital admissions among others (Scott, 2013).

Indeed, essentially all SWCMG has moved away from programmed to a shared decision-making model, and the general steps in this process are normally as follows:

1. **Make yourself accessible to clients:** First and foremost, SWCMs must ensure that their access is always available for clients and family systems.

2. **Develop good “listening ears”:** Listening carefully to clients and client systems about what their needs, issues, concerns are, and what their ways of communicating are, is essential in developing any helping relationship with any client in any setting.

3. **Establish trust in each phase in the process:** SWCMs certainly understand the importance of building trust relationships with their clients. Using skills such as, empathy,
compassion, giving hope, answering all questions honestly, etc., are essential in this trust-building process, and foster a more open climate to render all joint decisions.

4. **Information giving**: Providing necessary and timely information in ways clients are able to understand it, is central to both effective communication and joint decision making.

5. **Providing referrals**: Often, not just clients but their support systems, require referrals to a host of legal, health, educational, and social services, to make more informed decisions during the care process.

6. **Determining client resources and assets**: During the entire helping relationship, SWCMs not only have to assess fiscal/insurance/liability/eligibility, and personal and community resources, but client strengths, their motivation, and internal assets in order to assist clients through their process of shared decision making in their overall care planning.

7. **Facilitating family system communication**: Shared decision making occurs at numerous points in the CMG process. It also occurs with clients, and their family systems. SWCMs are reminded that this “system of care” evolves, as often these members come essential to the decision making process to help keep all communication doors open with all stakeholders. This is particularly challenging when families are displaced by geographic distance, limited resources, lack of availability, and/or pre-existing strained relationships.

8. **Assessing providers**: Bringing providers into the care plan as required, now presents “new set” of options in which joint decision making has to be reconsidered and done by SWCMs.

9. **Brokering for services**: Like #8 above, when a) service providers, b) availability and access, c) client eligibility, and d) client resources come together, in order to move a client forward to the next step in his or her care plan, yet another venue for joint decision making that being the brokering for services, arises in which a satisfactory resolutions have to be made for all parties, as new situations frequently pop-up in the process.

Although the above nine steps essentially are nested in Phase 1, or the Assessment/Planning Phase of SWCMG as evidenced above, shared decision making is an important aspect of not only this phase, but throughout the entire client-centered care process. This is deemed yet another distinguishing characteristic separating CMG work from traditional social casework.

**Output Driven → Outcome Driven**

Often in the social, behavioral, and the helping science professions, we misuse and confuse these terms. Outputs refer to something achieved or produced by a person or thing for example, a SCWM made 50 referrals last month. Outcomes refer to measurable benchmarks used which convey change, for example, 20% of elderly clients in the physical exercise intervention started exercising on their own, 3 times a week, for a minimum of 10 weeks. The former is about units of activity, the latter about units of change, usually as a result of the planned activity (Holosko & Thyer, 2011).

SWCMs are always looking at the big picture surrounding their client, whereas many clients often can’t see the next step in the process, as they are currently stuck in...
their stressful current step, for example, assessing their own support systems, (or more bluntly—will my children help me now?). It is this constant focusing on the eventual outcomes of the entire case and care process that SWCMs do not take for granted. This is why many CMs including SWCMs are called terms like *navigators, client navigators, community liaisons, coordinators, system navigators, brokers, advocates*, etc. (see glossary page XX for a more complete list of these terms)—as they move their clients through a mutually agreed-upon care plan in order to achieve a desired outcome. For instance, many health and mental health SWCMs are required to specify in the client’s care plan all short, intermediate, and long-term outcomes that were crafted as the planning process unfolded. Then during the care process, these outcomes are tied to the decisions and options that clients make, as they shape their eventual and likely outcomes, which may need re-thinking and revision all through in this arduous process.

**Role Delineation → Role Blurring**

It is difficult for SWCMs to practice effectively in many settings particularly health care, if they are not comfortable with the concept of role blurring. Many SWCMs work in settings as members of a multidisciplinary team of different collaborating professionals all of whom bring their “professional hats” to the “client’s treatment table.” The necessity to be comfortable with one’s own professional self and one’s knowledge, values, and skills is crucial to being a valued and respected team player in such settings.

Beyond the self-awareness and self-efficacy of who you are and what you do is the necessity to understand who others are, and what they do. In health and mental health settings, projected by the U.S. Department of Labor to be the major growth areas for social workers in the next 9 years, SWCMs will become more involved with client/patient care, and require a partial and working knowledge of issues such as disease symptomology, medical terminology, drug terminology, the DSM-V, electronic data systems, legal agreements, client rights agreements, technical eligibility standards, financial planning, employment pensions, billing, insurance eligibility criteria, living wills, licensing issues, capability assessments, capability assessments, health and mental health policies, and best practices, etc. These knowledge and practice areas extend far beyond the current curricula of any BSW or MSW programs currently offered in North America.

Our longstanding cognate discipline nursing, has professionally endorsed the importance of role blurring for eons. However, having such knowledge does not dilute the professional identity of the SWCM, rather it strengthens it. In a nursing study titled “Knowledge of the Professional Role of Others: A Key Interprofessional Competency,” MacDonald and colleagues (2010) identified six key competencies required for successful inter-professional practice (IPP) and collaboration. These included communication; strength in one’s own professional role; knowledge of professional role of others; leadership; team functioning; and negotiation for conflict resolution (p. 238). These were then subsequently selected for further study, and the main essential competency used to define specific practice behaviors was *knowledge of professional roles of others*. Thus, role blurring not only is part-and-parcel of effective SWCMG—*it is essential to our professional development.*
Generalist Practice → Advanced Generalist Practice

BSW accredited curricula in North American schools of social work are anchored in the generalist practice method, first developed for teaching purpose by Louise Johnson in 1986. Upon completion of their required courses and internships, BSW students graduate as entry-level generalist practitioners trained to work primarily in direct practice. When these graduates become employed as case managers or SWCMs, they often have a steep on-the-job learning curve, both from the standpoint of necessary education/knowledge/skills and training about how to practice effectively, but also about maintaining their own professional social work identity in these settings. Despite their lack of formal education/training in case management, which is the norm for the majority of BSW students, many of these individuals are “up for the challenge” of developing their careers as case managers in a variety of settings. It is their motivation to professionally grow and develop and learn, that tends to offset their acknowledged lack of education to do their job directly after graduation.

MSW programs however, stream BSW and related undergraduate majors that is, psychology, sociology, education, criminology, etc., into 1-year advanced study programs. The MSW accredited degree is still anchored in two streams, micro or direct practice chosen by the majority of MSW students (75%), and macro or indirect practice. Curriculum-wise, these streams are offered as mutually exclusive, parallel tracks of study, with distinct core courses, distinct internships, but overlapping electives, in general. Indeed, many MSW students are forced to choose a micro or macro preference early on in their programs, sometimes before they actually arrive at the school’s doorstep.

Given your reading of this text up until this point, and noting the previously identified and various tasks/knowledge, skills and expertise required to practice effectively as a SWCM, you may reach the same conclusion that we offer at this point. In the MSW accredited educational programs, the coerced distinction between micro and macro practice is a false dichotomy, and one that is out of synch with many social work occupations in the real world, not just the case management field. A consensual definition of advanced generalist practice (AGP) is, “the practice of a master social worker who possesses advanced competencies in multilevel, multi-method approaches and is equipped to work in complex environments that may require specialized skill sets” (Rondero Hernandez, 2013).

First, AGP requires students to move seamlessly and smoothly, up and down the micro-to-macro continuum to effectively do their job with clients and client systems. Its second essential feature is that all interventions must be anchored either in “best” or “promising” practices or by policy directives and/or empirical findings, or evidence-based practice (EBP). The push for the incorporation of these two elements in AGP has been documented by many in this field (Segal, 2013; Simmons, 2012; Singer, Gray, & Miehls, 2012). For example, in their study conclusion in developing a 12 evidence-based step approach to improve chronic care patients’ self-management and/or health outcomes, Battersby and colleagues (2010) concluded:

Healthcare is in the midst of a transition from expectations that disease will be managed primarily by physicians to a system that enables patients to effectively assume primary
responsibility for managing chronic conditions. There is now a substantial evidence based that can be used to guide efforts to improve the abilities of healthcare teams to enable their patients to successfully manage chronic illness. The challenge before us is to integrate those evidence-based principles into routine patient care. (p. 567)

**Bureaucracy → Technological Bureaucracy**

If you think that bureaucracies are already mired in numerous forms, regulations, guidelines, protocols, and reams of paperwork, as they say in the rock song by Randy Bachman, “You Ain’t Seen Nothing Yet.” Due to the nature of CM, where clients navigate through numerous systems of care with numerous providers along the way, SWCMs quickly realize that paperwork has increased exponentially and has moved to computerized technology. This essential skill is not just a requirement for SWCMG, but it is a necessity.

In addition, contemporary SWCMG has become highly bureaucratized; and the field has entered into the digital age of computers. Four areas where computer technology is being used with increasing frequency are a) providing online services and information to clients, b) documentation, c) electronic medical records, and d) for health information. Each of these areas not only requires computer skills and savvy, but has their own set of compelling ethical issues that require practitioner competence. These include privacy and confidentiality, informed consent, client’s rights, conflict of interest, termination and interruption of service, consultation and client referral boundaries and dual relationships, documentation, research evidence, technical standards, billing and insurance information, legal issues, and who can access such information (Mullin, 2012; Reamer, 2013).

In an article written by a coalition of social work organizations/associations intended to provide social work best practice standards for hospital case management anchored in NASW’s 1996 Code of Ethics, the sub-section just on “documentation” from the aforementioned list (above) included:

**Documentation**

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

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

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

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

Social Work Case Management Documentation is to be signed by the Case Manager with the individual’s specific professional credentials identified (MSW, ACSW, etc.) (Society for Social Work Leadership in Health Care, 2014).
As you can surmise, the information age impacts SWCMs significantly, with increased paperwork, bureaucratization, and computerization. Ongoing training and education to stay abreast with these realities are the norm for SWCMs employed in a range of health and human service settings.

Concluding Remarks

As indicated throughout this contextual chapter, like other social workers, SWCMs do not work in a vacuum. They are influenced daily by international, national, political, organizational, policy, and resource trends. This chapter identified selected main contextual trends that shape our day-to-day practice. What we have come to realize as a profession, is that in order to professionally survive, social workers must continue leading with the hallmark characteristic of our profession’s DNA that is to continue to adapt and transform. We are fortunate that this is part of our profession’s legacy.

We then presented 10 key transformational trends that SWCMs must fully embrace in order to adapt in this regard. Although targeted to the “trending domains” (those areas that lead other area of CMG practice) of health and mental health, we contend that existing curriculae in North America BSW and MSW programs are sorely lacking in preparing social workers to work effectively in this area. Indeed, this was a main rationale for writing this text, and as you read on, we hope that you will gain the necessary knowledge and skills to offset this deficit in your existing education.

REFERENCES


