DEPRESSION, DIABETES AND DESPAIR: CLINICAL CASE MANAGEMENT IN A MANAGED CARE CONTEXT

JOEL KANTER, M.S.W., L.C.S.W.

ABSTRACT

In this presentation, the authors will describe a clinical case management[1] approach with a severely depressed, diabetic man conducted with the support and collaboration of the managed care department of a major insurer. Addressing both the cost concerns of the insurer and the medical and environmental needs of the insured, the implications of such efforts for social work practice in a managed care environment are discussed by the case manager and the insurer's nurse care manager.

As managed mental health care has expanded over the past decade, the limitations of this approach have been outlined by many authors (Kanter, 1995a; Kramer, 1996; Shapiro, 1996). Two of the most common criticisms have involved the lack of adequate treatment for the most disturbed patients and the ineptness of the managed care reviewers. In this article, we will present a case report of a successful intervention with a severely disturbed and medically vulnerable man that was conducted with the support of the managed care department of a major insurer. In this situation, the needs of the patient and insurer converged and the social worker implemented a clinical case management approach (Kanter, 1989; Kanter, 1995b) that would not have been funded by traditional capitation plans. While an atypical situation, this report illustrates some of the potential benefits of case management intervention in a managed care environment.

Case Report

Paul was referred to me three years ago by his psychiatrist on a general psychiatric ward in a local hospital when I was working as a case manager in private practice. A 37-year-old man, he had been

[1] As there is considerable semantic confusion around the term "case management", the author will use this term to describe a "hands-on" social work approach; the term "care management" will be used to describe the telephone and referral activities of managed care staff.

Smith College Studies in Social Work, 66(3), June 1996.

transferred to this ward from a medical unit where he had been admitted after a hypoglycemic diabetic episode. Paul had been an insulin-dependent diabetic since age 30, and his diabetes had been out of control since the death of his father, who had become blind and lost a foot 20 months earlier as a result of diabetes. Living alone in his own apartment, he had been hospitalized at least six times in that period for both high and low blood sugar and had refused to allow home health nurses in his apartment. An adopted only child, Paul had apparently become increasingly isolated as his mother, his main social support, became terminally ill with cancer. He had been employed as a mail clerk for a government agency, but had obviously been unable to work for some time.

When his internist recognized that Paul's near-muteness and dramatic weight loss prevented effective medical intervention, he transferred Paul to the psychiatric unit where he was placed on anti-depressant and anti-psychotic medications. As he had no social support system and was uncommunicative, it was difficult to take an adequate history. His educational background suggested a severe learning disability or minimal brain dysfunction, but there was no evidence of prior psychiatric hospitalizations. His hospital psychiatrist quickly recognized that Paul's lack of social support would greatly impede effective discharge planning and he asked me to evaluate Paul on the ward for case management services, especially finding him a supportive living situation.

When I met Paul on the ward, I was immediately struck by his emaciated body, dishevelled appearance, his sad, blank expression, and monosyllabic verbal responses. Diagnostically, it was impossible to discern whether he was suffering from simple schizophrenia, a more paranoid disturbance, or a very severe depression. Organic brain syndromes were also a possibility. Yet, diagnosis aside, I had to consider how we could find a safe living situation for him in the next few weeks. This was complicated because Paul would tell me nothing about his financial situation: Did he still have a job? Any sick leave? Any funds in the bank? Without this information, case management planning was impossible. Quickly aware that our dialogue would be very limited, I introduced myself, sat with him quietly for a time, and asked his permission to contact his mother (which had not been done by the hospital staff).

Two days later, the hospital was contacted by Paul's aunt, who told them that his mother had died the day before I saw him. She had been buried earlier that day and the few relatives had chosen not to inform

the hospital of her death until after the funeral. There were no relatives in the area. The aunt who lived 200 miles away had had little contact with Paul. No one in the family or our community had had much, if any, contact with Paul in recent years. With the psychiatrist's permission, Paul's aunt visited the hospital to inform him of his mother's death. She was accompanied by an acquaintance of his mother, Mrs. T., who had been appointed co-executor of the mother's estate (with the aunt) and the trustee for a trust established by the will to assist with Paul's care and medical expenses. Mrs. T. had not known Paul's mother well, and had never met Paul before, but had agreed to serve as trustee when his mother prevailed on her after the death of Paul's father. Apparently, Paul's parents had also been quite isolated and had no good friends in the community, a fact that emerged when I learned more about the eight people who had attended the funeral.

Although Paul expressed little emotion about his mother's death or the fact that he was not invited to the funeral, I hypothesized that the death of his parents had considerable significance and proposed a graveside memorial service. This was held before his aunt — his closest relative — returned home. Paul received a pass from the hospital to attend the service. We invited his aunt, the trustee, and three neighbors to attend — the only members of his network we could identify. At the cemetery, Paul also saw his father's grave for the first time as he had not attended his funeral either. I read a few prayers and allowed Paul to meditate alone at the gravesite. Afterwards, I went out for lunch with Paul and his aunt. He was silent throughout the meal, but his aunt talked throughout, expressing her belief that her sister's cancer could have been cured if the American Medical Association and the National Institute of Health hadn't conspired to conceal the cure from the American public.

Paul returned to the hospital and improved marginally over the next few weeks. His weight stabilized and he seemed more expressive non-verbally, though he still was largely mute. Insurance pressures were demanding discharge. We still didn't know if Paul had a job or any funds; he flatly refused to discuss financial matters during my frequent visits. By this time, we had learned about the trust that his mother's will had established and gained the support of the trustee to assist in funding case management services when the estate cleared probate. With the trustee's support, I attempted — without success — to locate someone informally who would take Paul into their home as I knew that all formal residential programs would take

months to evaluate and admit him. Finally, insurance mandated a discharge date and although his psychiatrist and I did not know how he could cope in his own apartment, we decided that I would drive him home and see if we could somehow help him cope with daily contact.

Paul was visibly anxious when I transported him to his apartment and verbally expressed his hesitation about going home. When he opened the door, I was stunned by the disarray covering every inch of the apartment. Looking for a place to sit, I could not find anywhere to place the items that had been on the chair. Picking up the telephone, I could not get a dial tone; this was very disturbing to me as I viewed telephone contact as essential. I was unclear whether the equipment was defective or the line was dead — and Paul would not tell me. We went out to a pay phone and I called the phone company. They told me that the phone service had been discontinued because the bill had not been paid in several months. As it was a weekend, there was no way service could be restored for at least 48 hours. Mulling things over and looking at Paul's anxious, depressed, and uncommunicative state, I could not imagine how he could survive safely in the community and called his psychiatrist to recommend readmission. His psychiatrist understood my dilemma and called in a readmission order immediately. Fifteen minutes later, I returned Paul to the hospital.

After another five days without much clinical improvement, Paul's psychiatrist spoke by phone with a nurse care manager (Madeline Silva) at Paul's insurer. Her role is to develop special, out-of-benefit, treatment plans for patients with unusual medical conditions. Although Paul was obviously suffering from a severe mental illness, he was eligible for this assistance because 1) he had a serious "medical" condition (diabetes) which had not responded to conventional medical interventions, and 2) this condition had led to repeated hospitalizations which had been very costly for the insurer. In a combination of self-interest and altruism, Paul's insurer, through the care manager, worked out a discharge plan where they paid for him to go into a high-quality convalescent home and retained me as a case manager to find him a permanent living situation as his medical and psychiatric condition stabilized. Specifically, I was authorized to spend up to 20 hours monthly helping Paul; we understood that my activities would include developing a rapport with him in visits to the nursing facility, collaborating with the staff in the nursing facility, making phone calls with possible residential providers and other collaterals, and prepar-

ing whatever written materials were necessary. I submitted a monthly diary of my services with my bill, and called Ms. Silva, the care manager, whenever I had a question about whether the insurer would support a given activity.

Ms. Silva had not made a similar plan for any other patient, but Paul's case was clearly an unusual one. In making this plan, she acknowledged that she discussed a budget for this intervention with her supervisor, using a formula which balanced the cost of the out-of-benefit services against his medical utilization in recent years.

Gradually, with the help of antidepressant medication and persistent social support, Paul's depression diminished and he appeared to look forward to contact with me. I often took him out of the nursing facility, buying him new clothes and sometimes eating at local restaurants. He continued to be evasive about his financial or vocational situation, and seemed very pleased at the care he was receiving in this facility. He initially was given a single room and he enjoyed watching TV all day, with meals brought to his bedside (a regression from the expectations on the psychiatric ward). I arranged with the nursing staff to transfer him to a double room so he would be less comfortable in the facility and more motivated to collaborate with me in finding an alternative.

Meanwhile, I did not have an easy time finding a suitable residential placement. The psychiatric programs were very uneasy about working with a non-compliant insulin-dependent diabetic and the geriatric placements were concerned about his psychiatric condition and his age. Finally, after two months, I located a suitable foster home that would accept him, but we then discovered that we had major problems in settling his mother's estate and funding the trust that would subsidize his placement. Without assured funding, the foster home accepted another resident.

Around this time, Paul had improved to the point where he was able to return to work. I called his supervisor, provided them with adequate documentation of his medical and psychiatric condition — documentation which helped them understand his lack of communication with them for over four months — and negotiated a part-time return to work while Paul continued to reside in the nursing facility. Paul clearly needed significant income beyond the small stipend offered by the trust to support a residential placement. Although he probably would have had little difficult retiring on disability, his resources would have been extremely limited and his quality of life would have been diminished.

Paul, however, was ambivalent about returning to his job and expressed a wish to remain indefinitely in this nursing facility. After conferring with Ms. Silva, she agreed to take the unusual step of visiting Paul in the nursing facility and informing him that his stay in this facility was contingent on his participation in a plan that would return him to work and independent living. If he did not wish to participate in this plan, his insurer would not continue their unusual, time-limited support for his care. Without a job, he would probably only be able to afford care in a less desirable institutional setting.

This confrontation was a critical moment in Paul's recovery as Paul struggled with his regressive tendencies. Although angered that he would not be able to remain indefinitely in this institution, he agreed to return to work. However, he still would not collaborate with me about financial matters and I had no assurance that he would pay his rent.

To obtain a residential placement, it seemed necessary that he have a financial guardian. Arranging this posed yet further complications. Who would petition for guardianship? Who would pay an attorney to provide legal services? Who would serve as the guardian? Interestingly, the insurer agreed to pay attorney's fees and I was charged by the insurer's legal counsel to retain an attorney competent in guardianship proceedings. I then recruited the trustee to serve as petitioner, the attorney located a colleague to serve as guardian, and a guardian was finally appointed nearly eight months after Paul had entered the nursing facility.

Throughout his stay in this facility, I also had to address the problem of Paul's diabetes. First, I had to educate myself about this condition. Second, I had to consult continually with the facility staff to engage them in helping Paul to self-administer his insulin instead of doing it themselves. If he could not self-administer his insulin, his range of residential options would be extremely limited and he likely would require institutional care. As one might expect, skilled nursing facilities are not equipped to help "thirty-something" young adults handle their own medications and go off to work each morning. This was a particular problem because shifts changed during the critical period when Paul had to be awakened to go to work, given his insulin, and encouraged to eat a healthy breakfast.

Finally, I was surprised to find myself constantly addressing diabetic emergencies. The first occurred when I visited Paul at lunch hour when he was beginning to eat from his lunch tray in his bed; after taking a few bites, he went into what I later learned was a hypoglycemic

seizure and lost consciousness. I stayed with him though the seizure and then attempted to find a nurse. No one was working on his wing of the facility, and finally I called the front desk. Paul was taken to the local emergency room, but was discharged back to the nursing facility in several hours. Acknowledging my own anxiety, I immediately knew that such incidents would cause major problems for most residential providers.

During his stay in the facility, he had at least four more similar incidents. Two occurred while he was at work, and I learned that Paul had rushed out in the morning without having breakfast. On both occasions, I called and went to the emergency rooms. When the physicians could quickly diagnose the diabetic emergency and understand that Paul had adequate outpatient medical care and social support, he was discharged safely within hours when his blood sugar had stabilized. As these incidents had previously resulted in hospitalizations of three to seven days, the insurer's care manager was very appreciative of these cost-saving interventions. Over time, I learned more and more about diabetes and how it uniquely affected Paul.

Of course, there were significant psychological problems underlying all of these problems. Although Paul's depression remitted significantly over the six months after hospital discharge (and he gained back 30 pounds), his learning disability, isolative tendencies, and characterological difficulties came to the fore. He was manifestly dependent, avoidant, and passive-aggressive. Ambivalent about employment and residential placement, he repeatedly asked if he could stay in the nursing facility forever. I was repeatedly amazed that a person his age would want to share a room indefinitely with feeble and dying persons. Thus, we struggled repeatedly with his reluctance to go to work, administer his own insulin, or control his diet effectively. The caretaking ethos of the nursing facility exacerbated the difficulties in addressing these issues.

Finally, after nine months in the nursing facility, I found a suitable "foster home" owned by a LPN in a neighborhood Paul liked, the guardianship was in place, and Paul was managing his diabetes more effectively. However, his mother's estate was far from being settled and we needed a court order to release a small portion of the estate to enable Paul to move. This hurdle was cleared too, and Paul moved into a new home over two and a half years ago.

Paul has remained in this home since with a dramatic reduction in the frequency and impact of diabetic emergencies (only one in the past year). Although a small stroke several months after his move

from the nursing home disabled him for several months, he returned to his job and self-administers his insulin and oral medications. After the initial year, the insurer's care manager terminated my special contract with them and I continue to work with Paul through the support of his standard mental health benefits and assistance from his trust. There are still many difficulties — especially chronic tardiness on his job and isolation — but overall Paul is much healthier and happier.

Discussion

Paul's medical and residential stabilization demonstrate the efficacy of a comprehensive case management approach which integrates psychological and environmental interventions in addressing both medical and psychiatric illnesses (Kanter, 1989, 1990, 1995b). Besides addressing the objective realities of a life-threatening medical condition and the near-absence of social support, I had to contain my intense countertransference responses to Paul's guardedness, passive-aggressiveness, and seemingly self-destructive neglect of his own health (Kanter, 1988; Maltsberger & Buie, 1974).

Case management with Paul required many component activities, including engagement, assessment, planning, resource development, consulting with a variety of caregivers, psychotherapy, patient psychoeducation and advocacy (Kanter, 1989). Yet, beyond these component elements, this intervention required a professional capacity to integrate knowledge from varying perspectives and operationalize this integration in pragmatic strategies (Kanter, 1987). For example, in working with Paul to prevent hypoglycemic emergencies, I had to both educate myself about diabetes and explore the complex psychodynamic factors involved in his difficulty in utilizing seemingly simple, preventive dietary strategies. Then, I had to understand the values and practices of the skilled nursing facility to obtain its cooperation in helping Paul learn these strategies.

Also, I hypothesized that Paul's unique combination of self-neglect and intense dependency reflected unresolved conflicts about his recently deceased parents. Although Paul's capacity to use insight-oriented psychotherapy was limited, my ongoing support for his grieving processes, involving at least three visits to his parents' gravesite after the memorial service, assisted him in developing more collaborative relationships with his caregivers.

Finally, this experience with Paul has demonstrated that a managed care approach to case management can work to address effec-

tively the needs of some persons with chronic psychiatric and medical illnesses. In fact, such an approach would never have been funded by a traditional indemnity approach to health insurance. The success of this intervention seemed dependent on the clinical knowledge, skill and judgment of Ms. Silva, the insurer's care manager, as well as on our capacity to develop an ongoing collaborative relationship (Mohl, 1996).

However, it is worth noting that these extracontractual services were made available to Paul only because he was a high-risk patient who had been a high-utilizer of services. In contrast, I recently described a case management intervention with a treatment-resistant young adult with schizophrenia who had been isolated in her parents' home for several years (Kanter, 1995b). Although the intensity of my interventions in that situation was only a fraction of my activity in Paul's case, the client's background of low utilization of services would have rendered her ineligible for the extracontractual benefits described above.

Furthermore, the insurer's cost-benefit assessment would support such an intervention only if the insurer had reasonable confidence that the insured would remain a beneficiary with the insurer for an extended period. In a competitive insurance climate where employers, employees and other insured persons often change insurers, there will be less financial incentive for insurers to "invest" in their customers' health; keeping this in mind, policymakers should consider the value of supporting stable relationships between insurers and their customers.

This case report illustrates how managed care can function rationally to allocate limited resources in the shared interest of insurer and insured. Although such an intensive case management approach is not likely to become part of benefit packages, it can be a useful extracontractual option in selected high-risk cases (an option not available through a traditional indemnity approach). Hopefully, other insurers and case managers can collaborate in implementing similar creative approaches which can maximize patient functioning while reducing long-term costs.

Commentary by Madeline Silva, R.N., C.C.M.

In the early '90s, many large insurers with traditional indemnity products were beginning to feel the competition in the marketplace from managed care products. Up until that time, care management

had focused on controlling costs for patients with costly catastrophic illnesses. As competition intensified, care management programs began to target chronic illnesses which required costly interventions. This enabled care managers to develop innovative care plans for individual patients which might more effectively address medical needs while containing costs. Paul's case was an early experiment in the care management of a patient with chronic medical and psychiatric illnesses.

Paul was initially referred to our medical care management unit from our company's psychiatric utilization nurse reviewer. She identified the Paul's clinical instability and the interrelationship between his psychiatric diagnoses, social situation, and medical history. She believed that he was at great risk for both medical and psychiatric recidivism.

When I spoke with Mr. Kanter, Paul's community-based social worker, and reviewed his hospital admission records, I learned that Paul's condition involved a major depression, an adjustment disorder to the loss of parents, borderline mental retardation, and mixed personality disorders. His medical history included many manifestations of Paul's inadequate management of his insulin-dependent *diabetes mellitus,* including hypoglycemia and insulin reaction, peripheral neuropathy, and seizures. A pattern of emergency or crisis management involving numerous emergency room visits and hospital admissions was evident.

Mr. Kanter and I discussed a range of treatment options of various intensity. After further discussions with the patient, treating physicians and the employer group representative, I completed a cost benefit analysis of a short-term care plan that would include transitional placement in a skilled nursing facility to provide a safe living situation and an active diabetes teaching and monitoring program. I also developed a long-range plan which involved Paul's return to work and a move to a group living situation with home health care support. We retained Mr. Kanter to focus on these longer-range goals: to provide Paul with counseling support on an as-needed basis and to locate and transition Paul to a group living situation with adequate support for his medical needs. Meanwhile, my role was to locate a suitable skilled nursing facility, negotiate rates, and monitor the ongoing interventions. Through weekly contacts, Mr. Kanter and I pooled our professional expertise and resources to plan a strategy and address various problems which arose over time.

Some of the major obstacles we addressed were:

1. Locating a skilled nursing facility with staff trained in diabetes management, on the bus line, that would take an adult patient with psychiatric difficulties;
2. Obtaining permission from the insurer to provide extracontractual benefits that would enable us to implement the aforementioned plan;
3. Educating Paul, his employer, Mr. Kanter, and the multiple caregivers and providers on handling medical emergencies while encouraging Paul to assume responsibility for his own health;
4. Addressing a variety of legal and financial requirements for guardianship, estate settlement and group home placement.

Reviewing the costs of Paul's care, records indicate that his claims totalled $53,000 in the year before the case management program began (including hospitalizations, emergency room visits, professional fees, medications, and labs); $84,000 in the year of the aforementioned intervention; $39,000 in the first year after; and $9,000 in the second year after. The costs in the initial year were perhaps twice what we expected because of the unforeseen legal problems we encountered around Paul's finances. In the next year, the majority of the costs resulted from Paul's stroke, another unforeseen occurrence. Yet, the dramatic trend toward cost reduction in this chronically ill man is clearly evident. Although our initial investment in these extracontractual benefits was higher than projected, Paul's clinical improvement, independent functioning and the long-term cost reduction has clearly justified our initial treatment plan. Without a doubt, Mr. Kanter's dedication, perseverance, and professionalism were the keys to the success of this individualized case management plan. I believe that this "gamble" in case management for chronic diseases became the model for the continuation and expansion of our company's chronic disease care management program.

References

Kanter, J. (1995a). Managed care and the seriously mentally ill consumer. *The Arlington Voice, 4*(3), 3-4.

Kanter, J. (Ed.). (1995b). *Clinical studies in case management (New Directions in Mental Health Services, No. 65).* San Francisco, CA: Jossey-Bass.

Kanter, J. (1990). Community-based management of psychotic clients: The contributions of D. W. and Clare Winnicott. *Clinical Social Work Journal, 18,* 23-41.

Kanter, J. (1989). Clinical case management: Definition, principles, components. *Hospital and Community Psychiatry, 40,* 361-368.

Kanter, J. (1988). Clinical issues in the case management relationship. In M. Harris & L. Bachrach (Eds.), *Clinical case management (New directions in Mental Health Services, No. 40)* (pp. 15-27). San Francisco, CA: Jossey-Bass.

Kanter, J. (1987). Mental health case management: A professional domain? *Social Work, 32,* 461-462.

Kramer, P. D. (1996). What's news. *Psychiatric Times,* 4.

Maltsberger, J. T., & Buie, D. H. (1974). Countertransference hate in the treatment of suicidal patients. *Archives of General Psychiatry, 30,* 625-633.

Mohl, P. C. (1996). Confessions of a concurrent reviewer. *Psychiatric Services, 47,* 35-40.

Shapiro, J. (1996). The downside of managed mental health care. *Clinical Social Work Journal, 23,* 441-451.