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Diversity in Case Management Modalities: The Summit Model

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ABSTRACT: Though ubiquitous in community mental health agencies, case management suffers from a lack of consensus regarding its definition, essential components, and appropriate application. Meaningful comparisons of various case management models await such a consensus. Global assessments of case management must be replaced by empirical studies of specific interventions with respect to the needs of specific populations. The authors describe a highly differentiated and prescriptive system of case management involving the application of more than one model of service delivery. Such a diversified and targeted system offers an opportunity to study the technology of case management in a more meaningful manner.

As behavioral health care is increasingly "managed", it becomes more critical to clearly define and delineate the various treatment interventions being prescribed and delivered. This is essential in order to assess the outcomes of each intervention, and to compare costs and efficiency across providers and regions. More importantly, it is the belief of the authors that clarity of service description will enhance the

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treatment planning process and ultimately lead to improvement in treatment outcomes for the long-term mentally ill.

Case management is one intervention which is almost universally mentioned as a cornerstone in the care of this population. (Kanter, 1989) However, as Bachrach has pointed out, there is as yet no consensus as to its definition. (Bachrach, 1981, 1992, 1993) Rather, it appears that a number of different, but related, interventions are carried out under this rubric. These share certain common elements, which lead Bachrach to describe case management as the "action component" of the concept of continuity of care. While noting these shared characteristics, Bachrach has also recognized that various models also differ in certain respects, and suggests that they may be "arrayed on a continuum with brokering and clinical approaches at the poles".

Solomon reviewed 20 studies of four different models of case management for severely mentally disabled adults. (Solomon,1992) She classified these as the Full Support, Personal Strengths (Developmental-Acquisition), Rehabilitation and Expanded Broker (Generalist) Models. A paucity of data as to the efficacy of each of these forms of case management was noted. In particular, she cited a need for studies of optimal length of service and intensity for certain sub-populations.

Most studies to date have compared one form of "intensive" case management to either minimal case management contact (Hornstra, Bruce-Wolfe, Sagduyu & Riffle, 1993; Quinlivan, Hough, Crowell, Beach, Hofstetter & Kenworthy, 1995; Durell, Lechtenberg, Corse & Frances, 1993) or to the very intensive PACT Model. (Dincin, Wasmer, Witheridge, Sobeck, Cook Razzano, 1993; Sands & Cnaan, 1994). Generally clients are randomly assigned to one or the other model. These studies have yielded less than convincing evidence as to the efficacy of case management. This may be due, in part, to the fact that the case management interventions were not targeted specifically to the client.

Dietzen and Bond (1993) have suggested that case management needs to be individualized for each patient. They find no correlation between case manager contact and outcome, as measured by hospitalization frequency, and suggest a clustering of clients according to his or her service utilization and preferences. This is contrary to the manner in which case management services are currently offered. Typically, a single form of case management, or at most two, are available within a particular agency. (Bachrach, 1995)

THE SUMMIT MODEL

Community Support Services, Inc. (CSS) is a private, non-profit agency created in 1988 to serve the needs of the most severely and persistently psychiatrically impaired in Summit County, Ohio. The population of this region is approximately 525,000. At the present time, CSS serves approximately 1850 individuals, of whom about 1650 receive case management services. Each of these persons is assigned to an interdisciplinary treatment team, according to an individualized assessment of his/her service needs completed by one of three master's level social workers, supervised by a Licensed Independent Social Worker.

Clinical services at CSS are provided by seven multidisciplinary treatment teams. Team members include one or two psychiatrists, approximately ten case managers, a registered nurse and a counselor, as well as representatives from residential services, vocational rehabilitation services, and the partial hospitalization program. A master's level social worker or counselor provides administrative supervision to the case managers, while clinical leadership for the entire team comes from the psychiatrists.

Case managers vary in educational background from master's level social workers and counselors to high school graduates, with substantial "hands-on" experience in working with the severely mentally ill. Case managers perform a variety of functions, including advocacy, transport of clients, symptom monitoring, medication compliance monitoring, assessment and teaching of community living skills, and provision of information and referrals. Formal counseling is done by those case managers with the requisite licensing and skills.

The treatment teams each have an area of specialization. Dually-diagnosed (substance abusing mentally ill) individuals are assigned to one of two "SAMI" teams. A certified drug and alcohol counselor is assigned to these teams, which are also closely integrated with a residential treatment program for this population. Staff on these teams receive special inservice training on issues related to substance abuse. Another team specializes in persons with both mental illness and mental retardation. All forensic clients are clustered on a single team headed by a forensic psychiatrist and forensic psychologist. Clients between ages 18–25 who do not have major substance abuse issues are assigned to a young adult team which focuses on developmental issues of adolescence which are often unresolved in this group. A geriatric

team serves clients over age sixty-five. In addition to standard case management, this team provides a senior citizens' activity group, as well as nursing home consultations. The latter is done by a three person sub-team, consisting of a geropsychiatrist, a licensed practical nurse, and a masters level licensed social worker. Clients who fit none of these descriptions are assigned to a "generic" team. Evening and weekend home visits for medication monitoring and support are available to all clients needing these services through referral to an Adjunctive Services Team.

In addition to the intensive case management teams, CSS operates an Assertive Residential Treatment (ART) Team, an interdisciplinary team based upon the PACT model. (Stein & Test, 1980) Clients are assigned to the ART team based upon a history of repeated psychiatric hospitalizations with short community tenure. These are the 55 clients felt to be most in need of continuous support and monitoring. This team consists of one psychiatrist, one registered nurse, and ten case managers, as well as representatives from residential, vocational, and partial hospital programs. Clients on this team are seen much more frequently than others. They receive one or more visits daily from case managers, who generally observe the client taking each dose of their oral medications. In addition, most clients are seen weekly by the psychiatrist. Most case management contacts, as well as some physician appointments, are done in the client's home.

The assignment of a particular primary case manager is done by the case management supervisor for the team, in consultation with the team psychiatrist. A variety of factors, related both to the client and the case manager go into this selection. Considerable attention is paid to achieving a proper "fit", or concordance of case manager and client characteristics. For example, the client may initially relate better to someone who more closely resembles him or her in age, race, cultural background, education, or other parameters. (Task Force, 1992) Those likely to benefit most from individual psychotherapy are often assigned to a case manager qualified to provide this in addition to other traditional support services. Clients who are evaluated as nearly ready for vocational training/rehabilitation are assigned to a "vocational case manager" who has specialized training and/or skills related to this area. These vocational case managers interact more frequently with our vocational unit than do other case managers, making communication during the transition smoother for the client.

Caseload size is also a factor. Clients who will likely consume large amounts of case manager time are assigned to workers whose caseload

demands will accommodate this. The most challenging of these cases are assigned to the ART Team which provides daily contacts with the client, as well as 24 hour accessibility, through a team case management model similar to that described by Lachance and Santos. (1995) Likewise, a similar outreach team works with the difficult to engage homeless mentally ill. Caseloads on these teams range from 6–10. The mean caseload for our agency is 28, but some case managers may carry as many as 40 relatively stable, non-demanding cases. This is most common on the geriatric team, where many of the clients are in nursing homes. Two nursing home specialists—a master's level social worker and a licensed practical nurse—share this population.

Individual clients may move from one case manager or team to another as they develop new service needs, or as previously unrecognized needs emerge. Continuity of care is a concern whenever this occurs, and efforts are made to transition the client gradually when possible. Frequently, a period of "co-management" takes place prior to formal transfer. Simultaneous changes of case manager and psychiatrist are avoided.

SUMMARY

Model programs cannot, and probably should not, be exported in toto. (Bachrach, 1988) Instead, promising programs should be adapted to meet local needs within the existing culture and resources of the community. Likewise, individual treatment plans should be tailored to the needs, culture and resources of the client. This includes the provision of case management services. A "one size fits all" mentality will no longer be acceptable as behavioral health care moves into the twenty-first century. The future of case management is in the custom-tailoring of services to fit the individual at each point in his or her illness and rehabilitation. In Summit County, we have taken steps in this direction by creating an array of case management services varying in intensity, methodology and diagnostic focus. These services are prescribed for each client according to their needs, taking into account such issues as diagnosis, comorbidity, stage of psychological development, vocational readiness, legal status, and housing needs.

Programs such as ours offer an opportunity to empirically test hypotheses regarding cost-effectiveness for individuals with various constellations of disabilities and needs. For example, the authors are currently conducting a study of outcomes and costs generated by our

Assertive Residential Team, as compared to the Intensive Case Management teams. Only through such research can we arrive at management decisions based upon clinical realities, rather than political imperatives.

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