Case management

By
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Introduction

- Need to coordinate different psychiatric services led to development of case management model
- Yet there is absence of a common definition for all users. A general one is “A strategy for distributing and coordinating services on behalf of patients” (Modrcin et al, 1985 Case management with psychiatrically disabled individuals. Lawrence, Kansas: University of Kansas)
Historical development

- In the US, a rapid expansion of human service programs – specialized services for narrowly target groups, which result in many uncoordinated, fragmented, duplication services. Integration programs are needed, and case management is one.
- Deinstitutionalisation demand reasonable continuity of service in the community, but they developed complicated adaptation problems in society. Case managers are opportune providers to fill the various needs
- Ref: Intagliata, J (1982) Schiz Bull, 8, 655-673
Historical development of ACT

- 1965-70 Arnold Ludwig, Arnold Marx & Mary Ann Test implemented innovative inpatient psychosocial programs to combat institutionalization at Mendota State Hospital, Wisconsin, resulting in better hospital adjustment & more ready for discharge. But no improvement in community adjustment. Joined by Leonard Stein, intensive postdischarge community aftercare program was provided, effective even for disturbed symptomatic patients.

- 1970- Total In-Community Treatment & Training in Community Living, Assertive Community Treatment Team, etc. were developed with positive results.

Definition

- A modality of health practice that, in coordination with the traditional focus on biological & psychological functioning, addresses the overall maintenance of the patient’s physical and social environment with the goals of facilitating survival, personal growth, community participation, and recovery from or adaptation to the illness.

Hong Kong definition

- A systematic process of assessment, service co-ordination, monitoring and evaluation through which the unique needs of clients are met
- Hospital Authority, 1995
Community psychiatric nurses as case managers

- Direct client nursing care at home (& injections prn)
- Continuity of care from hospital to community
- Often have administrative training & should be able to assess level of functioning & other needs including physical & psychological aspects
- Used to 24 hours shift work, with ease to call on medical/psychological support during crisis
- Introduced to community nursing services (general) in 1996 (Mackenzie, et al, 1997 Evaluation of a pilot project to introduce case management into community nursing services in Hong Kong. The Chinese University of Hong Kong)
Case managers

- In principle, every health care team member can be a case manager, but matching the most suitable person is essential for the success.
- Initially case managers are to refer to, coordinate and integrate various psychiatric services into a cohesive program best suited to the individual needs of the patients.
- Special features: individualised continuity of care, comprehensiveness (a variety of services), longitudinality (over time), supportive relationship with caregiver.
Case management functions & activities

- Assessment: information collection & integration
- Linking: aware of resources & barriers for devising treatment plan, support patient own responsibility
- Monitoring: notice changes though regular contact
- Assistance in daily living: encourage realistic independence, with direct/indirect assistance
- Crisis intervention: identify early warning signs, timely support
- Advocacy: identify gaps & needs
- NB collaboration between professionals & family members
Principles of clinical case management

- Continuity of care that address the patients need for an extended period
- Use of case management personalized relationship (a companion or guide rather than an agent)
- Titrating environmental support and structure (at optimal level) to patient’s changing needs
- Flexibility tailor the intervention strategies to accommodate the diverse needs
- Facilitating patient personal resourcefulness in self-management

Models of case management

- The broker model
- The clinician model
- The Assertive Community Treatment model
- The Intensive Case Management model
- The strengths model
- The rehabilitation model

Ref: Mueser et al, 1998 Schiz Bull, 24, 37-74
Modifications

- Modifications of all models for particular needs
- Success not always replicable
- Can be extended to other psychiatric disorders & less severe patients
- Can be quite costly e.g. small patient number
Intensities of case management

- **Minimum**
  - Outreach, client assessment, referral to service providers

- **Comprehensive**
  - The above + advocacy for client, direct casework, developing natural support systems, reassessment, advocacy for resource development, monitoring quality, public education, crisis intervention

Training of case managers

- Commitment & compassion
- Professional & clinical skills
- Human services & bureaucratic skills
- Team building & negotiating skills
- Teaching & communication skills
- NB Basic qualifications & experience, plus in-service training & adequate supervision & personal support
Optimal caseload

- A balance between newly referred unstable patients and long-term stabilized cases. Depends on the availability and accessibility of supportive services. Ranges from 5 (for high-risk group e.g. acute psychotic patients) to 50 per manager (Kanter, J (1989) Hosp & Commun Psychiat, 40 361-368)

- Too high caseload lead to managers becoming reactive rather than proactive; always on the run with little time to know the clients; to do things for clients instead of helping them independent; contact more determined by clients initiative, increased time to document their efforts rather than time with clients (Baker et al, 1980. Case Management Evaluation. Tefco Services, Inc., Buffalo, NY.)
Teamwork

- Via multidisciplinary group or an agency
- Advantages include
  - 1) more continuous cover & coordination (as unavailability of a single manager does not incapacitate the client)
  - 2) better planning based on more points of view, important for maintaining energy & creativity in working with chronic clients
  - 3) avoid isolation that may lead to burnout of the manager who faces tedious, endless and emotionally draining problems
Problems with teamwork

- Interagency suspicion & rivalry, with case managers caught in the middle
- Incoordination between inpatient & outpatient service
- Conflict with other members of the multidisciplinary team
- Role conflicts at work
- Vulnerable to sickness & holidays, and burnout
- Other administrative, legal & financial problems
Core tasks of care management

- Identify patients
- Assess needs
- Design care package
- Coordinate service delivery
- Monitor service delivery
- Evaluate effectiveness of services
- Modify care package
- Repeat cycle unless services no longer needed

Health economics of ACT

- Direct mental health Rx: in, out & day Rx
- Indirect Rx: gen medical Rx, social services, vocational training, recreational & avocational
- Law enforcement (police & judicial, probation & parole) & fire dept.
- Maintenance: cash payments, subsidies, services for basic needs (shelter, food, etc.)
- Family burden: cash, lodging & services to patients, lost of earnings, time off & adjustment to work
- Total costs = volume of services x unit cost

Societal costs of ACT

- Cost-accounting modified on Weisbrod. Resource use & cost data were collected for mental & physical health, social, law enforcement, other maintenance services & family services in a mobile ACT in Madison, Wisconsin (from clients & family members, private & public agency records & insurance claim files); 94 participants (no stat diff with non-participants).

- Results: average societal costs were US$23,061 in 1988. Maintenance costs were the largest share, followed by mental health Rx, family burden, indirect Rx & law enforcement. 85% of the financing came from the public sector.

Cost-effectiveness of ACT

- Costs & Benefits Analysis is affected by characteristics of various models*, the clients served, contextual factors (resources available & financial incentives built in)
- *affect resource management in 4 areas -
  - whether client or case manager is primarily responsible for directing the course of treatment,
  - whether reduction in hospitalization is a primary goal,
  - whether team management is used, &
  - how the size of caseloads is determined

Hong Kong (Mak, KY & Gow, L 1996)

- The employment of an aftercare social worker (generic, non-experienced at that time) for 30 chronic mentally ill patients discharged from half-way-houses of the Mental Health Association of Hong Kong
- Results: Cf to 30 matched control, just initial contact
- After 1st year: no difference
- After 2nd year: still no difference in BPRS (clinical)
  - decreased rehospitalisation due to relapses
  - Decreased ALOS
  - Increased employment (open or sheltered)
  - Decreased reliance on Public Assistance
  - Decreased law-breaking behaviour
  - Better QOL e.g. food & recreation
  - Cost-effective (despite increased expenditure (employment, instruction by researchers))
Hong Kong studies (Chan, S et al, 1999 J Advanced Nursing)

- In a controlled study using psychiatric community nurses as case managers, the experimental group had better mental status & level of functioning, with clients & carers perceiving that the service was beneficial, cf to conventional CPN service; and no sig difference between the costs
Conclusion

- Intensive care for certain severely disabled persons
- Personalised care better than generic care
- Qualification of case manager depends on needs, multi-handicap needs multi-disciplinary service
- Optimal caseload, duration of care not clearly defined
- Other rehab measures necessary (comprehensive care)