OMHAS Adult Case Management
(Evidence Based Practice Conceptualization for SB 267 Implementation)
Draft For Discussion Only: May 10, 2005

Since the inception of community mental health programs, a critical service for persons who have severe mental illness has been case management. Research has established that this component is generally effective in the treatment of severe mental illness.[1] Case management should be applied in various ways in mental health settings, and it should be tailored to meet the needs of specific client groups and service settings by varying the activities provided by case managers and the way in which case management is provided. Some dimensions that can be varied include focus, time frame, intensity (caseload), setting, availability, and frequency. Case management should also be viewed along a continuum, with differing levels of intensity used with different groups of consumers, based on the needs of the consumer. Case management is a flexible, fluid process that changes as the needs of the consumer change. So while a consumer may require a higher intensity model in the beginning, stabilization of symptoms and enhanced functioning may lead to need for a less intense level.[2]

Oregon proposes to use the National Association of Case Management Practice Guidelines where there are three ranges of case management: Level I (most intensive), Level II (medium intensity), and Level III (least intensive). At all three levels, access to Evidence Based Practices (EBPs) should be available to consumers depending on client choice and needs. The current EBPs that have been approved by SAMSHA and Dartmouth include the following: Intensive Case Management (ACT or Strength Base CM), Family Psycho education, Supported Employment, Illness Management and Recovery, Integrated Dual Disorder Treatment, and MedMap. As other practices become approved by the Office of Mental Health and Addiction Services (OMHAS) as being evidence based, Oregon will implement as toolkits and materials become available.

Case Management Practice Guidelines for Adults with Severe Mental Illness

[1] Ziguras, S.J. & Stuart, G.W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. Psychiatric Services 51(11):1410–1421.

[2] Salyers, M.P., Masterton, T.W., Fekete, D.M., et al. (1998). Transferring clients from intensive case management: Impact on client functioning. American Journal of Orthopsychiatry 68: 233–245.

National Association of Case Management (Adapted for Oregon)

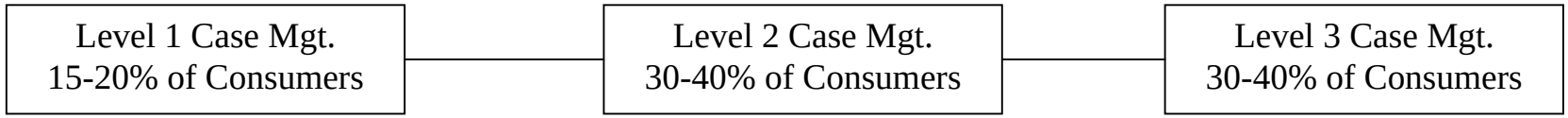
	Level I CM	Level II CM	Level III CM
Definition	Level I CM is the most intensive level of CM, directly providing frequent and comprehensive CM support to the most severely disabled adults 24 hours per day, 7 days a week. ACT or SB Model of CM is an example of this practice	Level II CM provides a 24-hour, 7-day goal directed type of CM which is recovery and outcome oriented for people who wish to make regular progress in growth and rehabilitation.	Level III CM is the least intensive CM mode provided to people who are at present satisfied with their role or are largely able to self manage much of their progress. Provided 40 hours per week with on-call for crisis intervention or other crisis intervention arrangements.
Admission	Diagnosis: Meets State criteria for severe mental illness. Recently DC from State Hospital; or High Utilization of Community Hospital; or Socially Disruptive Behavior w/ high risk of criminal involvement; or Imminent Risk of being homeless; or Civilly Committed in Community; or Living in a restricted environment such as foster care	Diagnosis: Meets State criteria for severe mental illness. No Recent Major Hospitalization and no Recent Criminal Involvement	Diagnosis: Meets State criteria for severe mental illness. Extended time w/ no Hospitalizations and extended time w/ no Criminal Involve
Focus/Activities	Focuses on obtaining basic human supports, decreasing symptoms and side effects of medication, increasing periods of independence, building support networks and minimizing or eliminating periods of crisis or severe dysfunction. Teaches and models positive behaviors and helps people reestablish sense of self and personal aspirations.	Focuses on obtaining recovery outcomes through maximizing strengths and developing, implementing, coordinating and adjusting person centered comprehensive service plan. Obtains and coordinates services and resources to meet objectives of plan, may teach skills. Provides consistent direct service support.	Focuses on maintaining stability and independence by providing a link to services, an interface with psychiatric and medication services and crisis prevention and intervention. Provides single, resourceful point of contact to mental health system, with emphasis on coordination and linking.
Caseload/ Mode	No more than 13 persons per case manager. Except in rural areas practiced in teams for 24-hour coverage and mutual support, but caseload may be assigned to individual case managers or team as a whole. Always includes one full or part-time nurse and psychiatrist per team. Job specialist and housing specialist included on team. In vivo practice with an average of 4 contacts per week.	20-25 persons per case manager depending on needs of persons served. Practiced in teams except in rural areas. Caseloads are individual. Single psychiatrist and nurse for caseload of team, job specialist and housing specialist on team. Range of contacts per month 4-11 based on individual need.	60-80 persons. Usually individual practice with some team features, i.e., group supervision, vacation backup. Largely office practice. Collaborates with medication service. Available for crisis prevention/intervention 40 hours per week with back-up arrangements at other times. Average 4 face-to-face and 8 telephone contacts per year.

Authorization/ Continued Stay	Initial authorization: 1 year, reauthorizations - 90 day intervals - continued stay based on degree of symptom and crisis reduction and/or positive response to treatment.	Initial authorization: 1 year, reauthorizations -90 day intervals continued stay depends on progress with rehabilitation goals and desire for further recovery progress.	Initial authorization: 1 year and every year thereafter as person chooses to have continued CM linkage to mental health system.
Expected Outcomes	Increased community tenure and reductions in the frequency or length of crisis or hospital services. Also, housing stability, decrease in symptoms and side effects, increased social integration, reduced impairment from substance abuse and decrease in level of care needed or desired. Consumer satisfaction.	Increased community tenure, decreased crisis episodes, increase in time spent working or in school, increase in social contacts, increase in personal satisfaction and independence. Achievement of independent or semi-independent living arrangements. Reduced impairment from substance abuse. Consumer satisfaction	Consumer satisfaction with personal life domains and continued stability as measured by no hospitalizations and a continued decrease in frequency and duration of crisis episodes. Increased personal independence in any life domain. Sustained recovery from substance abuse.
Movement	Indications for movement to a less intensive level of CM are: Sustained increased level of functioning; increased independence. Decrease in symptoms, crisis episodes, and hospitalizations, criminal involvement or satisfaction with life domains accompanied by decrease in crises and symptoms.	**Movement to Level III CM:** Persons can largely self-manage remaining objectives in service plan. No hospitalizations for 18 months, no crisis episodes for 6-12 months, or person chooses a less involved level of CM **Movement to Level I CM:** Increase in symptoms, increase in hospitalizations or criminal involvement	**Movement to Level II CM**: Increase in hospitalizations and crisis episodes, initiation or return to substance abuse, significant exacerbation of symptoms lasting more than 60 days. **Movement to Level I CM**: Significant increase in hospitalizations and crisis episodes, initiation or return to substance abuse, significant exacerbation of symptoms lasting more than 60 days. **Termination of CM Services**: Consumer choice, significant degree of independence and self management, strong positive family or significant other involvement.

Rationale for an OMHAS Adult Mental Health EBP Conceptualization

In Oregon most EBPs have been introduced in a piecemeal approach and rarely have been fully or consistently implemented, and fidelity to the EBP model has been rarely verified. This has resulted in a broad variance in clinical care, and few appreciable outcomes. By implementing a level system with a benefit design (on the following page 4), will ultimately result in better clinical and functional outcomes for consumers as well as improve efficiencies that allow maximum utilization of limited resources.

OMHAS Adult Evidence Based Practice Case Management Conceptualization



Characteristics
Low Case Load: 10-20
Community Based
Daily/Weekly Contact

Population Appropriate for Level
Persons With SMI and
Recently DC from State Hospital; or
High Utilization of Community Hospital; or
Socially Disruptive Behavior w/ high risk of
of criminal involvement; or
Imminent Risk of being homeless; or
Civilly Committed in Community; or
Living in a restricted environment such as foster care

Characteristics
Medium Case Load: 20-25
Community/Office Based
Weekly/Monthly Contact

Population Appropriate for Level
Persons With SMI and
No Recent Major Hospitalization and
No Recent Criminal Involvement

Characteristics
High Case Load: 60-80
Office Based
Monthly/Bi Monthly Contact

Population Appropriate for Level
Persons With SMI and
Extended time w/ no Hospitalizations and
Extended time w/ no Criminal Involve

Access to Evidence Based Practices (Benefit Design)

Surveys have repeatedly shown that persons with SMI often have limited access to EBPs. The following EBPs should be available to consumers with a varied degree of penetration:

ACT: 20%
SE: 60%
IMR: 100%
FPE: 100% (some kind of significant other)
IDDT: 40%

Practices	Definition	Population Served	Outcomes found in research studies/reference
Evidence Based Practices			
Supported Employment (Has A Fidelity Scale)	Is an approach to recovery for consumers with severe mental illness that helps them obtain competitive work in the community, and providing the supports necessary to ensure success at the workplace. The emphasis in the programming is helping individuals find jobs at competitive wages in integrated settings (i.e., with others who don't have a disability) in the community.	60% of adults with a severe mental illness desire work. 60% or more of adults with mental illness can be successful at working when using supported employment	• Effective for helping people to obtain competitive employment • Helps people to move beyond the patient role and develop new employment-related roles as part of their recovery process • Helps to decrease stigma around mental illness by helping people become integrated into community life through competitive employment • Increases self esteem and a consumers abilities to control symptoms of MI For more research information see: http://www.mentalhealthpractices.org/pdf_files/bond.pdf
MedMAP (Has A Fidelity Scale)	Is an approach in psychiatry which uses medication in a systematic and effective way as part of the treatment for psychiatric disorders. This approach includes involving consumers, families and other supporters, practitioners, and program leaders in partnership to make sure that medications are prescribed in a way that supports a consumer's recovery efforts.	Primarily for persons diagnosed with schizophrenia. Researchers are trying to expand to other SMI populations	• Use of medication algorithms show that, in general individuals treated with algorithms reported being more satisfied with their treatment and outcomes than individuals with the same diagnosis treated without algorithms at the same site. • The use of guidelines may reduce costs by eliminated ineffective practices For more research information see: http://www.mentalhealthpractices.org/pdf_files/mellman.pdf
Family Psycho-Education (Has A Fidelity Scale)	Family psychoeducation is a method of working in partnership with families to help them develop increasingly sophisticated and beneficial coping skills for handling problems posed by mental illness in their family and skills for supporting the recovery process.	Families of people diagnosed with the more severe forms of mental illness benefit the most from this treatment approach.	• For consumers whose families participate, relapse rates and re-hospitalizations decrease significantly within the first year following hospitalization. • Family psychoeducation programs have provided the psychosocial supports consumers need to extend recovery, re-enter the work force, and develop social skills. • Families report a decrease in feeling confused, stressed, and isolated. • Employment rate gains of two to four times baseline levels, especially when combined with supported employment, another EBP. • Medical care costs for family members are reduced as well. • Combined effects over several years lead to about 50% of consumers achieving five years without relapse, a very strong base for going on to recovery. For more research information see: http://www.mentalhealthpractices.org/pdf_files/dixon.pdf

Practices	Definition	Population Served	Outcomes found in research studies/reference
Integrated Dual Disorder Treatment (IDDT) (Has A Fidelity Scale)	Is an approach to recovery when a consumer receives combined treatment for mental illness and substance use from the same clinician or treatment team. The treatment approaches are practical life interventions which help consumer develop hope, knowledge, skills, and the support they need to recover from alcohol and drug use and to pursue meaningful life goals such as work and independent living.	40% of the adults with severe mental illness in public mental health systems are further impaired by the presence of co-occurring substance use disorders (abuse or dependence related to alcohol or other drugs).	Demonstrates positive outcomes in the following • Decreasing substance abuse, • Decreasing psychiatric symptoms, • Housing situations improve, • Hospitalizations decrease, • Arrests decrease, and • Functional status and quality of life improves. For more research information see: http://www.mentalhealthpractices.org/pdf_files/drake1.pdf
Intensive Case Mgt. ACT or Strength Based (Has A Fidelity Scale)	Assertive Community Treatment (ACT) is a multi-disciplinary, clinically effective, team based approach, providing proactive, focused, sustained care and treatment targeted at a defined group of consumers. ACT is aimed at ensuring that consumers maintain contact with services, reduce the extent of admissions and seek improvement with social functioning and quality of life. Strength based case management model minimizes illness and focuses on consumer strengths. Consumers are coached in setting their own goals and identifying realistic steps in order to achieve the goals. The primarily focus of the model is on securing natural community supports.	ACT or SB is most appropriate for individuals who experience the most intractable symptoms of severe mental illness and the greatest level of functional impairment.	• Lower use of inpatient services • Better quality of life • More independent living • Better substance abuse outcomes (when a substance abuse component is included) • Higher rates of competitive employment (when a supported employment component is included) • Greater consumer and family member satisfaction For more research information see: http://www.mentalhealthpractices.org/pdf_files/drake1.pdf Rapp. C. A. (1998). The active ingredients of effective case management: A research synthesis. *Community Mental Health Journal*, 34 (4).
Illness Management and Recovery (IMR) (Has A Fidelity Scale)	Is an approach to recovery when a consumer receives a series of weekly sessions in which a specially trained mental health practitioner will help consumers develop personal strategies for coping with mental illness and moving forward in life. The program can be provided in an individual or group format, and generally lasts between 3 to 6 months.	Designed for people who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression.	• Reduce relapses and re-hospitalizations. • Reduces distress from symptoms • Medications used more consistently For more research information see: http://www.mentalhealthpractices.org/pdf_files/mueser.pdf

OHP Codes for EBPs

EBPs:	OHP Codes:		
Case Mgt.	T1016 (QMHP CM)	T1016 HN (QMHA CM)	
Assertive Community Tx. or SB Model of CM	H0039 (QMHP ACT)	H0039 HN (QMHA ACT)	
Family Psycho Education	90849 (Multi Family Group Therapy)	908747 (Family Therapy with Consumer Present)	
Integrated Dual Disorder Treatment	G0177 (Training and Educational Services)	H2014 (Skills Training and Development)	90857 (Interactive Group Therapy)
Illness Mgt. and Recovery	G0177 (Training and Educational Services)	H2014 (Skills Training and Development)	
MedMap	90862 (Medication Mgt)	H0034 (Medication Training and Support)	
Supported Employment	H2023 (Supported Employment)	H2014 (Skills Training and Development)	

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