Email Alertings:  
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe:  
https://fulfillment.healthaffairs.org

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution
CASE MANAGEMENT AS A STRATEGY FOR SYSTEMS CHANGE

by Richard C. Surles, Andrea K. Blanch, David L. Shern, and Sheila A. Donahue

Prologue: Over the years, states have emerged as a dynamic venue for health policy experimentation. States often possess more political flexibility to move ahead on health care, while federal policymakers seem to lack the political will to break the health policy deadlock. New York State recently undertook a major intervention aimed at improving the mental health outcomes for its very disabled, disenfranchised citizens. This state experiment is using “intensive case management” to change its mental health system at a structural level to serve the most seriously mentally ill who previously experienced barriers to care. In this essay, the authors present their first-year program results. According to New York State Mental Health Commissioner Richard Surles, preliminary eighteen-month data not reported here confirm the program’s positive outcomes and show a continued improvement in results following an apparent plateau at twelve months. Surles, a leader among state mental health policymakers, received his doctorate in administration from the University of North Carolina at Chapel Hill. Andrea Blanch is director of the state’s Bureau of Community Support Programs. She earned a doctorate in psychology from the University of Vermont. David Shern, who directs New York’s Bureau of Evaluation and Services Research, received a doctorate in social psychology from the University of Colorado. Sheila Donahue is a research scientist in the department and received her master’s degree in economics from the State University of New York at Albany.
Case management in mental health has been used extensively in hospital and community services over the past twenty-five years. However, its use has varied such that the term case management now engenders images ranging from well-staffed teams of mental health workers directly providing support services to a set of administrative chores undertaken by clerks and accountants. Recently, both the public and private sectors have embraced case management as a potential strategy for improving patient care and support.

New York State has elected to use case management as part of a series of interrelated initiatives designed to create structural changes in its mental health system. Other key initiatives include a new budget structure, planning process, and performance contract mechanism; an agreement between New York City and New York State to reduce overcrowding in emergency rooms and acute inpatient units; a plan to create housing for 5,000 homeless mentally ill persons by 1993; a new Medicaid inpatient/outpatient rate methodology that provides incentives for serving more seriously ill patients and for linking discharged patients to outpatient programs; comprehensive reform of outpatient licensing, certificate of need, and Medicaid, financing regulations; and the development of new comprehensive psychiatric emergency services with specialized capacity for persons with diagnoses of both mental disorder and substance abuse. These initiatives affect the mental health environment by altering the legal, regulatory, policy, and resource base on which programs and services are designed and operated.

In the context of these broader initiatives, case management has played three strategic roles. First, it has provided a concrete mechanism for articulating and putting into practice the public mental health system’s responsibility for serving severely disabled and difficult-to-serve individuals. Moreover, it has defined that responsibility as an ongoing obligation to an identified target population, even while openly acknowledging that it may not be possible to serve and support all individuals. This commitment to a focus upon clients rather than on programs implies an ongoing responsibility to alter other aspects of the service system in order to improve clients’ chances for recovery. Second, it has been designed to identify barriers to successful treatment and to clarify public policy dilemmas that hamper access to services. This process provides the information needed for data-based decisions in areas of public policy that affect case management clients. Finally, it has been used to initiate a multifaceted process of leadership development and a realignment of decision-making authority. New relationships are being forged at the levels of direct care worker, supervisor, administrator, and local government authority.

In New York, intensive case management provides an initial focus,
ongoing feedback, and future guidance for existing and planned structural reform efforts. This case management program—called “intensive case management” to distinguish it from previous, less-targeted programs—is thus a key tool in the state’s long-range plans for change.

### Intensive Case Management As A Service Intervention

Intensive case management in New York emerged from the perception that the publicly funded mental health system was not effectively serving certain persons who were believed to require treatment. Local and state leaders, the popular press, and advocates all pointed to “the homeless mentally ill,” the “deinstitutionalized state hospital patient,” and the “dually diagnosed” as failures of the current system. Other labels used to describe these individuals included “treatment resistant,” “borderlines,” and “young chronics.” The public perception was that the mental health system was failing, while mental health professionals described legal, regulatory, and financial obstacles to assisting these highly visible persons.

Beginning in 1987, New York introduced an intensive case management program to test the capacity of the mental health system to respond to the needs of individuals who were not well served by the current system. As of early 1992, almost 600 intensive case managers have been hired, and a full statewide effort has emerged.

New York is a large state with profound economic, political, and cultural differences. As a result, the decision was made to develop a set of statewide principles for the new program but to permit local officials and providers to vary how programs were organized and services provided. General program parameters were based on the experiences of other case management programs for people with serious mental illness, including the Program in Assertive Community Treatment (PACT) model in Wisconsin; Washington, D.C.’s Community Connection program; Philadelphia’s Intensive Case Management program; the Thresholds model; and the Kansas Developmental-Acquisition model. The philosophy and values system combined principles of advocacy and empowerment with principles of psychiatric rehabilitation. The result is a public policy and financing strategy that calls for local program approaches with the following characteristics.

1. The person (client) is the central focus for the case manager, who aims to formulate positive goals with clients and to create appropriate opportunities for treatment, support, and rehabilitation.

2. Persons are “nominated” locally for participation in the program by those responsible for treatment. This process helps to ensure that the program remains focused on the target population. Once selected, per-
sons cannot be removed from the roster for “failure to improve,” without a court order or formal state approval.

(3) On average, caseloads are limited to ten persons per case manager. Variation can occur, with some areas using a team approach and others relying upon the backup of other professional staff.

(4) Activities are expected to occur in the client’s community. To serve clients living in high-risk neighborhoods, case managers travel together for home visits. Transportation and mobile communication are therefore important though sometimes difficult-to-fund components.

(5) Case managers are expected to be accessible either directly, on call, or through a rotation system with other case managers.

(6) Case managers serve as advocates and develop support for clients who are engaged and able to express goals and concerns. Assistance may range from helping a client to acquire medical, dental, and psychiatric care to arranging long-term access to housing, community supports, and rehabilitation. The role of case manager also includes teaching, modeling productive behavior and problem-solving skills, and helping the client to reestablish a positive sense of self.

(7) Services are not time limited. Developing long-term, nonprofessional supports (that is, friends, family, and other informal support networks) is also a key component of the intervention.

The philosophy underlying this approach is client centered and recognizes that clients may initially view the efforts by the case manager with suspicion, rejection, and anger. Nevertheless, an inherent expectation is to engage each individual, by altering strategies as necessary.

To translate these principles into practice, New York tried to develop supportive financing structures. The state adopted a capitated Medicaid financing strategy to provide case managers with the flexibility to spend time with clients as needed rather than being constrained by the need to generate revenue. In addition, a pool of “flexible funds” was made available to help fill service gaps and meet unique client needs. Spending of these funds was allowed to vary from region to region according to the existing base of available services, provided that at least 25 percent of the total pool be maintained for client-specific spending.

Although developing administrative structures to monitor and control these “flexible funds” was difficult, initial results are encouraging. Resource-poor rural regions have generally used the money to enhance their base of services critical to the successful functioning of persons with severe and persistent mental illness (for example, crisis beds). Areas with more resources have devised innovative ways of making the service system more responsive to clients. For example, in one county on Long Island, case management clients decide what new programs or services they would like to see developed, then “pool” their individual
accounts to support the new service for as long as they find it useful.

The New York program is not a replication of any one model. Instead, it is derived from tested principles and seemingly logical adaptation to a state with major variations in culture and problems. Intensive case management in New York is not intended to replace services, but to increase the demand for a range of health and mental health services, as well as for income, housing, and natural supports. This is in sharp contrast to many current case management programs that focus almost exclusively on reducing or justifying service use and containing costs. The New York State program took a position articulated by William Anthony and colleagues, Maxine Harris and Helen Bergman, and others that case management as a clinical intervention must be based on an ideology that is larger than cost containment. It is ideology should be a “uniquely human response to the client’s special service needs and overall goals.” When case management is seen in this light, studies that describe case management as a “failure” because it increases service utilization for some people could instead be interpreted as demonstrating “success.” In New York State, an appropriate increase in demand for services results from direct efforts to influence the behavior of two groups—the mentally ill among the homeless who ought to be in treatment and housing rather than in bus stations, shelters, and subways; and persons currently using emergency and inpatient care heavily.

Intensive case management tightly defines who is to be served; loosely defines expected outcomes (that is, increased engagement, decreased inappropriate hospitalization, and progress toward clients’ own goals); establishes a minimal set of standards for program operations; and provides structural and financial support for effective intervention. Some of the program’s initial flexibility was eventually lost to bureaucratic controls, but the program remains highly individualized from region to region. Although this regional strategy increases the risk that program goals will be lost or subverted as the program is implemented, the strategy reinforces the message that local providers and mental health authorities are responsible not only for delivering a service, but for developing systems of care that work for high-priority populations.

Case Management As An Agent For Policy Development

In New York, the assumption was made that the experiences of case managers and clients might help both state and local policymakers to better understand service systems, to confront existing barriers to clients’ progress, and to identify gaps in the long-term supports needed by persons with severe mental illness. Currently, both program evaluation data and direct information from clients and case managers are being...
used. For example, one region incorporates service needs identified by intensive case managers into the needs assessment used in developing their state-mandated local area plans.

The intensive case management program has already clarified some of the core issues now confronting the public mental health system. For example, should state and local mental health authorities act as housing agents or subsidize housing costs? Should special treatment programs be developed for mentally ill persons with significant substance abuse problems, for individuals with histories of sexual abuse, or for those who are human immunodeficiency virus (HIV)-positive; or should staff be oriented and trained to integrate all persons into modified treatment modalities? What role should the mental health system play for young parents who are mentally ill and who retain responsibility for their children? These issues were identified early in the program from anecdotal accounts. They have gained increased attention as statewide evaluation data reveal that these situations occur frequently (for example, 50 percent of all clients have substance abuse problems in addition to a major mental illness; 46 percent of young female clients have dependent children; and in one program, 50 percent of all clients have histories of childhood sexual abuse). Currently, policy discussions are occurring around each of these important issues.

Impediments to effective treatment and community integration have also begun to surface and to spark policy decisions. Outpatient and residential programs that are inappropriate, exclusionary, or demeaning have been identified and challenged. Programs that seek to maintain clients in an unwanted dependent posture have been confronted. Some overburdened social service agencies have attempted to “off-load” their legitimate responsibility to serve intensive case management clients and have precipitated high-level negotiations.

Probably the most powerful outcome of the intensive case management program has been reorientation of policy discussions from “services and treatment” to a focus on “person and environment.” In the past, public mental health policy has emphasized the development of capacity, access, and continuity. Capacity referred to the existence of basic services such as emergency, inpatient, and outpatient programs; access was related to hours of operation, location, and availability of clinical staff; and continuity referred to coordination between treatment modalities. Few mental health policy discussions ranged beyond this domain.

Intensive case management has focused attention on the variety and complexity of needs of the seriously mentally ill, and on the presence or absence of opportunities for meeting these needs. New issues such as the impact of culture, community structure, and family, and opportunities for jobs, housing, and valued roles have emerged as important considera-
ctions. For the most seriously ill and disabled, these factors may be as important as mental health services or treatment.

If case management programs operate in isolation from policy- and decision-making structures, the existence of larger social barriers to successful treatment can be a source of tremendous frustration for case managers. However, if channels of communication are open, policy issues quickly become more focused, and public discussion broadens to include coordination of natural supports, formal entitlements, and provision of equal access to other health services and opportunities. Public policymakers gain a new perspective on problems and potential solutions, and case managers gain the satisfaction of having played a part in sparking a dialogue that could potentially affect their clients’ success.

**Evaluation Of Intensive Case Management**

A systematic evaluation of the intensive case management program is an integral component of the systems change strategy, emphasizing accountability for the program and focusing on client outcomes. The evaluation was designed so that each of the important components of the program was assessed with an emphasis on investigating both the effectiveness of the program overall and the differential effectiveness of variations in program models, staffing arrangements, and experimental reimbursement strategies. An implementation evaluation was conducted during the first program year to document the various ways in which the program principles were put into operation throughout New York. A client-focused outcome evaluation is the core of these various evaluation studies. While a minimum set of descriptive data and identifying information is collected on all clients enrolled in the intensive case management program, a 20 percent random sample of clients is followed longitudinally in a single group pre/posttest design. These clients are assessed by their case manager using a highly structured protocol every six months following their enrollment in the program. Ultimately, this single group design will be augmented by adding a matched contrast group of clients outside of the intensive case management program who resemble program clients in their clinical status and service use profile. Medicaid claims data will then be examined to determine the impact of program participation on service use patterns.

Descriptive data on 4,297 intensive case management clients indicate that the program has been successful in recruiting a population that is distinct from the general population of individuals who are classified as seriously and persistently mentally ill. The typical intensive case management client is young (62 percent under age forty), male (61 percent), unemployed (87 percent), single (93 percent), and a nonminority group...
member (61 percent). Young men represent 51 percent of the intensive case management program clients, compared with 30 percent of the general population of seriously and persistently mentally ill individuals (p<0.01). When the intensive case management cohort is compared with a general population of seriously and persistently mentally ill persons with similar age and gender characteristics, 89 percent of intensive case management clients have a diagnosis of major mental illness (schizophrenia and major affective disorders), as contrasted with approximately 86 percent of the population of individuals classified as seriously and persistently mentally ill (p<0.01). Intensive case management clients are judged to be significantly more symptomatic than the general seriously and persistently mentally ill population in the uncooperative/suspicious symptom scale (p<0.01) of the expanded Brief Psychiatric Rating Scale. In contrast, intensive case management clients are rated significantly lower on the thinking disorder subscale (p<0.01) than their counterparts classified as seriously and persistently mentally ill. Nearly 80 percent of intensive case management clients have a secondary disability-mostly problems related to alcohol or substance abuse (55 percent of the sample). Compared with the general seriously and persistently mentally ill population, intensive case management clients are twice as likely to be judged a danger to self (12 percent versus 6 percent) or to others (9 percent versus 4 percent) (p<0.01). In addition, intensive case management clients are significantly more likely to be judged to have a moderate or severe problem with substance abuse (25 percent versus 9 percent) or alcohol abuse (28 percent versus 11 percent) (p<0.01). These data indicate that the process used to specify clients for the intensive case management program was successful in identifying a young population with multiple disabilities that is experiencing severe mental health problems.

Changes in clients’ unmet service needs, psychiatric status, inpatient utilization, and quality of life are assessed at six-month intervals to determine program outcomes. Baseline, six-month, and one-year data in these areas have been collected for 219 intensive case management clients in the 20 percent outcome sample. Since the program began more slowly in New York City than in upstate areas, this client sample proportionally underrepresents New York City. Simple pre/post comparisons for each of these areas are briefly discussed below.

Changes in unmet needs for the first year of the program are portrayed in Exhibit 1. With the exception of dental services, significant declines in unmet needs (p<0.05) occurred during the first six months in all service areas assessed. All eight areas showed significant reduction in unmet need during the first year of the program. Interestingly, again with the exception of dental services, all of the reductions occurred during
the first six months of program participation. This plateau effect may indicate the discovery of new unmet needs following engagement with the client or the difficulty in meeting intensive case management clients’ needs in the existing service environment. The lack of an ongoing reduction aside, however, these data indicate that participation in the program has resulted in a modest reduction in unmet need for services across a relatively broad array of human service needs.

Symptoms and problem behavior patterns comprise the measures of psychiatric status included in the longitudinal outcome analyses. Five subscales of the expanded Brief Psychiatric Rating Scale are included: anxiety/depression, thinking disorder, uncooperative/suspicious, withdrawal/retardation, and agitation. No changes in these symptom scales occurred during the first six months of the program. However, after a year, clients were judged to be significantly less withdrawn (p<0.05) and to show a trend toward decreasing anxiety (p<0.06). Problem behavior is assessed in three areas: potentially harmful behavior, antisocial behavior, and alcohol/substance abuse. Harmful behavior references potential harm to self or others, while the antisocial scale includes inappropriate sexual behavior, property damage, and so on. In contrast to symptoms, significant reductions in the alcohol/substance abuse problems (p<0.05) occurred during the first six months of the program. These reductions were also evidenced at one year, as was a significant decline in potentially harmful behavior. Case managers reported that no changes occurred in antisocial behavior during the first year. The psychiatric status indicators, therefore, showed fewer areas of positive change during the first year than other measures of unmet need. After one year of program participation, intensive case management clients were judged to be less
anxious and withdrawn and to have less severe problems with alcohol/substance abuse and potentially harmful behavior than at enrollment.

Since the evaluation is still in its early stages, the analysis of changes in service use following enrollment in the program is limited to the use of state inpatient resources. Data on inpatient utilization were extracted from the statewide database and include all state inpatient stays for one year before and one year after enrollment. Significant reductions occurred both in mean number of admissions and in average number of inpatient days. Admissions dropped from an average of 0.48 per six months prior to intensive case management participation to 0.26 following enrollment ($p<0.01$). The number of inpatient days was reduced from 46.4 per six months before the program to 30.0 ($p<0.01$) for the 219 individuals being followed in the longitudinal outcome analyses. The stability of the utilization pattern during the two six-month periods before the program started helps to rule out regression to the mean as an alternative explanation for these results. As with the unmet needs analyses, the major reduction in mean inpatient utilization occurred in the first six-month follow-up period, with no additions or changes in the second half-year interval.

Quality-of-life indicators for this analysis include victimization, use of community resources, and social relationships. Social relations are assessed by a four-item scale that measures whether the client has a relationship with program staff, family, and peers both within and outside of the mental health system. Community resource use is measured by a six-item scale assessing the client’s involvement in recreational activities, use of public facilities, and participation in community groups. All three areas show significant improvement following a person’s enrollment in the intensive case management program.

These preliminary results are encouraging. The program was intended to serve the most needy component of the population. Characteristics of the intensive case management client population, particularly in contrast to the general population of individuals classified as seriously and persistently mentally ill, indicate that the targeted population has been successfully enrolled. Through advocacy, service linkage, and brokerage, case managers were able to decrease levels of unmet need. Use of state inpatient services has also been reduced, while modest improvements in clients’ psychiatric status and more general improvements in quality of life have been observed in the first year of program participation.

**Discussion**

The New York State mental health system is complex, conflicted, and highly political. At the time the intensive case management program
was initiated, many observers viewed the system as being in a continuous state of crisis. Massive problems of homelessness, acquired immunodeficiency syndrome (AIDS), substance abuse, and hospital overcrowding threatened to overwhelm the system's capacity to respond. The situation demanded immediate action that would produce fast results and also set the stage for long-term change; a strategy that would involve multiple parties in developing solutions; and an intervention that would provide a clear focus while simultaneously allowing a wide variety of issues to be addressed. Case management provided one vehicle for all three demands.

Case management in New York provided what has been termed a “nonsynoptic method” of social change. When a high degree of complexity precludes simple solutions and a high degree of conflict makes quick consensus unlikely, effective change requires methods that are both indirect and systemic. Intensive case management incorporated the three aspects of change necessary in these conditions—an evolving theme; action as part of defining change (rather than as a consequence of change); and a large number of people involved in defining and creating new structures and relationships over time.

Implementation of the intensive case management program has not been without problems. The flexibility of the program was not familiar to either governmental or nonprofit providers and created considerable anxiety about fiscal and legal liability. This led to confusion about the Office of Mental Health’s intentions and, in some cases, to the imposition of unnecessary rules and mandates at the local level. The role and responsibilities of intensive case management are also outside the framework of many providers. For example, intensive case managers were seen as adversarial by some families and agencies. Also, legitimate concerns arose about safety of staff and clients, in large part due to a lack of experience with the population and the service modality. Additionally, the program generated resentment among several groups, including other case managers who perceived themselves to be doing similar work for less status and money; some social service agencies that perceived intensive case management clients to be receiving special treatment; and locally operated intensive case management programs, which provide less pay and fewer benefits than state-operated programs.

Early data indicate that the program is achieving valued outcomes. State inpatient use has been reduced, while clients’ level of unmet needs, psychiatric status, and quality of life have been improved. The rate of change, however, has plateaued at one year. It is unclear if this lack of ongoing change indicates problems in gaining access to services, inadequacy of services given the complexity of client needs, the maximal gain that may be expected from this program, “bureaucratization” of
the program, or any number of other explanations. These various alternatives will continue to be explored within the evaluative research project. These findings will also be used with program managers, intensive case managers, consumers, and state policymakers in forums throughout New York in an ongoing attempt to stimulate improvements in the program and change in the New York State mental health system. Perhaps this concentration on ongoing monitoring and accountability best expresses the ultimate program goal: to continually challenge the service system to facilitate the recovery of the most severely ill.

NOTES


17. Ibid.