Psychiatric nursing case management: Past, present and future

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Abstract:

This literature review examines the evolution of psychiatric nursing case management in the United States. Various models, both inpatient and outpatient, are described, along with the roles of the case manager in each setting. The development of clinical pathways to monitor and document outcomes in acute settings is examined, along with the difficulties in adapting them specifically to psychiatric nursing case management. The types of data collected and the use of outcomes to support programs for the mentally ill are reviewed. Finally, recommendations for psychiatric nursing case management are made to provide guidelines for the future.

Keywords: psychiatric case management | case management | nursing | mental health care

Article:

With the advent of managed care, shorter stays in hospital, and a focus on continuity of care across the health care system, case management (CM) has become a prevalent model for health care delivery in the United States (Platter, Vaughn, & Young, 2001). A variety of models for delivering CM services in inpatient and outpatient settings have been described; however, CM varies from one practice setting to another and from one population to another. Cohen and Cesta (2001) found certain identifiable characteristics of CM. These include a collaborative approach that provides "coordination, integration and direct delivery of patient services and places internal controls on resources used for care" (p. 7), and an emphasis on "early assessment and intervention, comprehensive care planning and inclusive service system referrals" (p. 7). Finally, the overall goal is to balance cost and quality components to achieve good outcomes. According to Stroul (1996), the intent of CM is to mobilize, coordinate, and maintain an array of services and resources in order to meet the needs of individuals over time. Huber (2000) noted that the core functions of CM are risk management and coordination of care; Tahan (1999) described CM as a process that also includes outcomes evaluation, monitoring, and utilization review.

Although psychiatric nursing case management (PNCM) was developed following deinstitutionalization as an essential component of a community support system for the mentally ill, only recently has CM become a part of inpatient psychiatric services. This review examines the evolution of psychiatric nursing CM. Various models, both inpatient and outpatient are described, along with the roles of the case manager. The development of clinical pathways (CPs) to monitor and document outcomes in acute settings is examined, along with the difficulties in adapting them to PNCM. The types of data collected and the use of outcomes to support programs for the mentally ill are examined; finally, recommendations for PNCM are made to provide guidelines for the future.

THE EVOLUTION OF PSYCHIATRIC/MENTAL HEALTH CASE MANAGEMENT (PCM)

PCM first occurred during the 1950s when U.S. veterans returning from World War II experienced psychiatric problems. Since that time, the Veterans' Administration has provided a model for PCM which addressed veterans' needs for social services, health, and mental health (Kersbergen, 1996). According to Tahan (1998), the concept of a continuum of care emerged, with emphasis on providing client-centered, coordinated, and comprehensive care for psychiatric patients. During the 1970s, CM services were developed in community mental health (CMH) centers across the nation, to provide psychiatric support for patients adjusting to the community after living in state hospitals for years. CM programs for the chronically mentally ill (CMI) were staffed by nurses, social workers, and paraprofessionals (Herrick, 1985). According to Kersbergen (1996), “Deinstitutionalization of the mentally ill and disabled in the 1970s had a major impact on the refinement of the case management process” (p. 170). In the late 1970s, federal support came for the establishment of CM programs in CMH centers through legislation stipulating that the mentally ill must be assigned a program coordinator. CM was considered critical to integration of services for the deinstituionalized (Kersbergen, 1996).

Since the 1970s the goal of PCM has been to keep the client in “the community and out of the restrictive and costly environment of the hospital” (Platter, Vaughn, & Young, 2001, p. 92). Although CM was perceived as important for adult psychiatric patients as early as the 1950s, CM services for children and adolescents were unavailable until the 1980s. The Child and Adolescent Service System Program (CASSP) was established by the federal government in 1984 to help state mental health departments coordinate care for severely emotionally disturbed (SED) children, adolescents, and their families. Interagency projects were federally funded to address a fragmented system of care, under the auspices of CASSP. System of care (SOC) projects established CM services that included assessment, coordination of care, advocacy, and referrals to community resources. Additional services expected from case managers included outreach to homes, crisis intervention, teaching parents child management skills, medication monitoring, acting as liaison to schools serving SED children, and establishment of day treatment programs (Pearson, 1995).

The Education of the Handicapped Act Amendments of 1986 (P.L. 99-457) was passed to improve services, including mental health services, to infants and toddlers with special needs and their families. Public Law 102-321 (ADAMHA Reorganization Act, 1992) authorized the establishment of the Center for Mental Health Services, which provided program grants to

establish community-based SOC programs for SED children. The legislation identified CM as a critical component of community based services for families of SED children (Stroul, 1996). Today, SOC, which provides CM services across the continuum of care, is considered best practice for the care of SED children with complex needs (M. Arbuckle, January 20, 2003, personal communication).

CASE MANAGEMENT MODELS

A variety of CM approaches to psychiatric/mental health care for children and families have been tried (Stroul, 1996), and CM models continue to evolve to serve a diverse population of the mentally ill. Huber (2001) has categorized CM models as the following: (a) "within the walls" (acute care), (b) "beyond the walls" (community and continuum of care), (c) "the broker model" (traditional social work model), (d) "the collaborative model" (interdisciplinary model), and (e) "the disease management model" (focused on a population, both within and beyond the walls).

Within-the-Walls Models (Acute Care)

Inpatient PCM Model

Waltham Weston Hospital developed a model of CM that is initiated in the Emergency Department (ED). Every psychiatric patient who arrives at the ED is assigned to a managed care agent (MCA) who performs the original assessment and remains accessible to the patient throughout the hospitalization. The MCA, who may be a psychiatrist, therapist, or other psychiatric clinician, becomes part of the treatment team wherever the patient is assigned. The MCA is expected to meet the immediate needs of the patient and is accountable to and for the patient 24 hours a day, 7 days a week during the hospitalization. The MCA acts as the patient's advocate and makes decisions about the intensity of care with input from other service providers, but is ultimately responsible as the expert on a particular patient's care. The MCA then refers the patient to a variety of services, including crisis intervention, respite care, partial hospitalization, and traditional inpatient care. The MCA acts as a case manager, interacting with the patient, family, other health care providers, and third party payers to obtain access to the appropriate resources. This inpatient model is designed to balance costs and quality. Olsen, Rickles, and Travlik (1995) noted that the advantages of the model are that services are immediately accessible, one person is accountable for the welfare of the patient during the entire hospitalization, and there is an extra layer of support for the patient and family from the MCA, who assists the patient to move as quickly as possible toward a timely discharge.

Beyond-the-Walls Models (Community Care/Continuum of Care)

Continuum of Care PCM Model (The Colorado Model)

The Colorado Psychiatric Hospital/University of Colorado Health Sciences Center has developed a PCM model that combines brief solution focused therapy, assertive community treatment (ACT), and family-centered interventions which include family preservation techniques. The continuum of care model provides a bridge between hospital psychiatric care and community care (Platter, Vaughn, & Young, 2001). The model was developed to rapidly reintegrate mentally

ill patients back into the community. The inpatient program includes an intensive inpatient locked setting, a 24-hour open setting, and a partial/day treatment setting that is transitional for those preparing for discharge. Progression through the program is individualized based on the patient's needs (Platter, Vaughn, & Young, 2001). The patient, family, and community members are participants in developing the treatment plan. Therapy focuses on goals, concentrates on concerns that address current circumstances and available resources, builds on individual and family strengths, and supports autonomy (Vaughn, Webster, Orahood, & Young, 1994). Upon hospitalization, a case manager is assigned to partner with a patient in order to guide the patient and family across the continuum of care, from inpatient to outpatient. He or she develops and facilitates the treatment plan, coordinates the efforts of other providers, documents the client's progress, and maintains working relationships with third party payers. Each case manager serves as a hospital/community liaison. The accompanying outpatient program, The High-Intensity Treatment Team, provides a range of therapeutic and rehabilitation services. The PCM continues to be an advocate for the patient from admission to post-discharge (Platter, Vaughn, & Young, 2001).

Most patients have done well with the shorter stay this model provides, but a small percentage have needed longer hospitalization, especially those with acute mania or severe psychotic disorders and those who had toxic reactions to their medications.

The Broker Model

Community Mental Health (CMH) PCM Models

The original mental health centers established in the 1960s and 1970s used the Broker Model to care for deinstitutionalized psychiatric patients. CMH PCM models have combined the broker model with a disease management model (DMM) to form a psychosocial model to care for the chronically mentally ill (CMI). CMH PCM services include crisis intervention, supportive psychotherapy, family support, medication management, and other non-psychiatric services including housing, vocational training, and rehabilitative services. CMH PCM services are individualized to support independent living. CM provides a safety net or life-line for the CMI and is designed to provide 24-hour care throughout the individual's life span (Corrigan & Garman, 1996; Ford & Beasemoore, 1995; Rohde, 1997).

Scott and Boyd (2001) have described two community-based CM models to care for the CMI, the Program for Assertive Community Treatment Model (PACT) and the Intensive Case Management Model (ICM). Both programs are community-based, but they have lower staff/patient ratios than are usually found in traditional outpatient CMH programs. The PACT Model uses a team approach, while the ICM model uses an individual partnership between the case manager and client. Both models have been able to document decreased rehospitalization. Shorter hospital stays improved housing stability and greater independence, all of which lead to a better quality of life for the client.

Interdisciplinary or Collaborative Models

A Dyad Model: For an Inpatient CM Team

In this model, social workers (SWs) and nurses (RNs) form partnerships to manage patients during hospitalization and discharge planning. Each contributes his or her expertise in managing the patient's care. In a southeastern U.S. psychiatric inpatient hospital, a counselor, SW, and a psychiatric RN make up the case management team (Bartlett, Jones, & Herrick, 2003).

System of Care (SOC) Model for Severely Emotionally Disturbed Children (SED)

The SOC model evolved from the original CASSP projects and has developed into a philosophy with core values and principles about "the way in which services should be delivered to children and their families" (Stroul, 1996, p. 3). The SOC model is strength-based. Huber (2001) described a strength-based model as one in which the case manager assists clients to achieve personal goals by helping them to identify, secure, and sustain resources to live and carry out other work and play activities in their home community. SOC core values include the belief that services should be child and family centered, community-based, and culturally competent, and SED children and their families should have a comprehensive network of services across the continuum of care. Further, relationships among agencies should be collaborative in the best interests of the child and family (Stroul, 1996). Treatment should be conducted in the least restrictive setting. The "wraparound" concept, which is integral to the SOC philosophy, includes a set of policies and practices to coordinate services "around" the family, to meet the "specific concerns of children and families with complex needs" (Handron, Dosser, McCammon, & Powell, 1998, p. 68). The goal is for the SED child to remain at home, in school, and in his or her own community. Services are wrapped around the child and family so that children receive holistic care (Handron et al., 1998). The case manager makes referrals and coordinates medical and psychiatric care in order to overcome barriers to care for the child and family. Services may include mental health, public health, medical care, juvenile justice, the schools, social, recreational, or vocational services, substance abuse services, and other services identified by the child and family as important to their welfare.

CM is a unifying factor in the SOC model (Stroul, 1996). Parents are encouraged to actively participate in developing and implementing their child's treatment plan and are considered the experts as to what is best for their child. Extended family members are included in the interdisciplinary CM team, which can be led by any of the mental health disciplines. Collaboration is valued and interagency resources are pooled to address the complex issues of a family with an SED child (Stroul, 1996). CM involves brokering services, collaborating with various disciplines and agencies, ensuring that an adequate treatment plan is developed and implemented, monitoring the child and family's progress, and advocating for the child and family when they are unable to advocate for themselves. Wrapping services around the family enables children to remain at home, which is cost effective, and enhances quality of life for the child and the family. Although the SOC model is currently a community model, it also could be a continuum of care model. The Colorado Model, for example, has elements of SOC values that could easily be incorporated into a continuum of care for children.

Health Care Model or Disease Management Model (DMM)

The DMM model offers outpatient and rehabilitation programs focused on a specific population over the life span (Huber, 2000). The DMM serves patients who are chronically ill and at risk for high costs, such as chronic obstructive pulmonary disease (COPD) or AIDS. CM may be considered a DMM for the chronically mentally ill, because it focuses on one population and there is a commitment to provide continuity of care across the life span.

ROLE OF THE NURSE CASE MANAGER

The role of the nurse case manager (NCM) depends on the model under which the NCM is operating, organizational goals, the population being served, the setting, and the situation. Conti (1996) found that NCMs working under the Broker Model identified their roles as being a public relator, educator, expeditor, monitor, problem solver, explainer, negotiator, planner, communicator, contractor, recommender, broker, researcher, assessor, documenter, and coordinator. Throughout the literature, CMs have been noted to serve in a variety of roles, as a case finder, planner and broker, change agent, monitor and overseer, coordinator, collaborator, consultant, resource manager, financial advisor, researcher, and lastly, educator (Cohen & Cesta, 2001; Conti, 1996; Mullahy, 1998; Ritter-Teitel, 1996). Few models identify direct care as the responsibility of the case manager. However in rural areas, where there are shortages of health care providers, the case manager may have to wear two hats, one as a care provider and the other as a care coordinator (Brown & Herrick, 2002). Some private health care organizations have hired mental health professionals to serve both as therapists and case managers in psychiatric managed care settings (Thomas, Dubovsky, & Cox-Young, 1996). Bushy (2003) noted that often "by default nurses who work in home health, community mental health and social services are expected to assume case management responsibilities" (p. 221). Huber (2001) suggested that the NCM is pivotal to "overseeing critical paths, facilitating interventions, and coordinating activities" (p. 266).

CLINICAL PATHWAYS (CP) IN PSYCHIATRIC NURSING CASE MANAGEMENT (PNCM)

A clinical pathway (CP) or critical pathway is a "multidisciplinary management tool that depicts important events that should take place on a day-by-day sequence" (Powell, 1996, p. 364). The CP was developed in 1985 by the New England Medical Center as part of its CM program, to identify expected patient outcomes within specified time frames (Hampton, 1993). Another label for this process is the Multidisciplinary Action Plan (MAP) (Cohen & Cesta, 1997). As in other settings, the CP for PCM is defined as a "tool for case management to organize, sequence, and time the major interventions for patients" (Chan & Wong, 1999, p. 146). Unfortunately, CPs for psychiatric patients are still rare and the literature on clinical pathways in psychiatric case management is limited to 'how to develop a CP.' Several authors have used models developed for acute care, primarily surgery or orthopedics, to develop CPs for psychiatric care. These authors noted, however, that adapting the CP from surgery to psychiatry was not easy (Hancock & Sherer, 2000).

CPs have not been developed in psychiatry primarily because of the variability of psychiatric patients who have the same diagnosis. For example, Jones (2001) has noted that the "diagnosis of schizophrenia does not lend itself easily to predicting care and treatment within a care

pathway framework" (p. 58). Nevertheless, the goals for psychiatric CPs are similar to those for other specialties, that is, to (a) ensure the best outcomes, including decreasing costs and length of stay (LOS) and improving the quality of care; (b) promote interdisciplinary collaboration; (c) standardize care by increasing consistency and tracing variances in order to decrease them; (d) facilitate coordinated services in order to enhance the continuity of care; (e) optimize the use of resources; and (f) improve documentation.

CPs have been developed to care for patients with schizophrenia by Chan and Wong (1999) in Hong Kong and Jones (2001) in England. Dunn, Rodriguez, and Novak (1994) developed the "Coor-Plan" (p. 25), a CP that addressed four psychiatric disorders commonly found in adults and children. Their focus was on both stage of life and diagnosis. Each diagnosis was associated with a "problem statement, outcome criteria and interventions that could be selected by the staff to formulate a plan of care" (p. 26). Local and national norms for diagnostic category and age group were used as benchmarks for determining LOS. Bultema, Mailliard, Getzfrid, Lerner, and Colone (1996) developed a CP for depression with suicidal and homicidal ideation and inability to perform self-care activities. Brown, Griepp, Buckley, James, and VanderMolen (1998) developed a system and process-focused care map that was divided into three phases with a specified number of days, behavioral expectations, and a list of responsibilities of each team member for each phase. The goal was to "help staff identify universal and individual goals and assist in keeping patients progressing at an optimal rate" (p. 35). Hancock and Sherer (2000) developed a generic CP for any psychiatric patient and four other CPs that were diagnostically related—for dementia, depression, detoxification, and psychosis.

Improved Outcomes as a Result of CP Utilization

Several beneficial outcomes of CPs for PCM have been identified. These include (a) improved quality of care, (b) decreased LOS, (c) improved interdisciplinary collaboration, (d) increased consistency as a result of standardizing care, (e) enhanced continuity of care, (f) better use of resources, and (g) improved documentation (Chan & Wong, 1999; Dunn, Rodriquez, & Novak, 1994; Hancock & Sherer, 2000).

Dunn, Rodriquez, and Novak (1994) reported improved patient care outcomes and a decrease of eight days in LOS, over a period of a year after implementing the Coor Plan. Bultema et al. (1996) also reported a decreased LOS using a CP for depression. Hancock and Sherer (2000) found that targeted behaviors identified on their CP decreased in severity and concluded that the patient's quality of life improved as the quality of care improved. Chan and Wong (1999) noted that nurses perceived that the quality of their care improved, as reflected in an increase in their patients' functioning. Patients also reported that they were more satisfied with their care. Chan and Wong also documented nurses' increased satisfaction with autonomy and professional status.

Dunn et al. (1994) and Hancock and Sherer (2000) found improved interdisciplinary collaboration and education through the use of CPs. Chan and Wong (1999) said that the CP promoted the use of a common language and thus team members developed a better understanding of each other's responsibilities. Several authors have noted an increase in the consistency of care with the use of CPs. Hancock and Sherer (2000) found that staff were able to

establish predictable patterns of care for specific patient groups while still individualizing care, and as a consequence there was a decrease in variation among providers. Chan and Wong (1999) concluded that nurses were better able to implement interventions and achieve desirable outcomes within a specified timeframe. Dunn et al. (1994) reported better documentation of "detours" which improved staff accountability. Care delivery was documented on the CP by superimposing actual occurrences over desired ones, which provided immediate feedback.

Use of CPs also helped case managers optimize resources, using the most appropriate resources for each phase during the course of care. Nurses were more aware of resource utilization by using the CP (Chan & Wong, 1999). Brown et al. (1998) concluded that the CP is a "viable tool for enhancing patient care and optimizing resource use" (p. 35). However, since most of the reports on CPs are anecdotal, more systematic studies are needed to examine the advantages of using the CP in psychiatric mental health care.

OUTCOMES MANAGEMENT

Outcomes management involves determining the effectiveness of care, identifying interventions to improving patients' health status, determining costs, and identifying barriers to improving access to care (Farnsworth & Biglow, 1997; Zander, 1988). In a study to evaluate advanced practice in psychiatric nursing, Barrell, Merwin, and Poster (1997) provided a summary of tools that may be used to measure outcomes in advanced psychiatric nursing (APN) and NCM. These outcomes can be divided into two categories: the first is cost, which includes LOS, recidivism and emergency room visits, access to care, and use of resources; the second category is quality, which includes quality of life, functional status, patient satisfaction, and symptom management (Ethridge, 1989; Mateo & Newton, 2002; Robinson, Robinson, & Lewis 1992). The most frequent positive outcomes found in PCM studies included reduced LOS and recidivism rates, improved functioning, including returning to work for some patients, and greater medication compliance. These outcomes added up to cost savings (Holloway, Oliver, Collins, & Carson, 1995; Malone, Workneh, Butchart, & Clark, 1999; Thomas, Dubovsky, & Cox-Young; 1996; Thomas et al., 1997).

It is difficult to document positive outcomes when psychiatric patients are persistently and chronically ill. For example, patients who have periodic bouts of psychosis or severe depression frequently suffer from the side effects of medication; they repeatedly stop taking the medications and then experience an exacerbation of symptoms, necessitating readmission to the hospital. Measuring quality of life for these chronically mentally ill patients is difficult. However, symptom reduction, decreases in self-destructive acts, improved functioning, and living independently in the community or with families are all positive. Malone, Workneh, Butchart, and Clark (1999) also reported improved social support for participants who attended a group CM program for mentally ill veterans.

A number of positive outcomes have been identified in SOC, including: (a) fewer child hospitalizations and decreased LOS; (b) fewer out-of-home placements and for children placed outside of the home, more likelihood of remaining in their communities; (c) improved behaviors and school performance; (d) fewer contacts with law enforcement, fewer incarcerations and days in detention; (e) decreased high risk behaviors, including sexual behaviors; (f) increased

children's and parents' satisfaction with their care; and (g) reduced costs (Rogers, 2003; Stroul, 1996).

CONCLUSION

This review of psychiatric case management suggests that (a) PCM needs to adapt and refine CPs to better document interventions and outcomes, (b) reliable and valid tools to assess outcomes must be developed, (c) outcomes studies must be rigorously conducted, (d) comparative studies of CM programs should be conducted to determine the most cost effective quality care, and (e) systematic multi-site research must be a priority for the future.

CM appears to have a bright future but outcomes management must be continual to verify its importance. Case managers must see changes as challenges and opportunities to grow, knowing that the quality of health care is improved through their efforts. At a recent CM meeting, the speaker commented in an off handed way: “If you cannot manage change, you do not belong in CM” (personal communication, The American Case Management Association, Winston Salem, October 24, 2003).

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