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Integrated Services for Long-term Care

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INTRODUCTION AND BACKGROUND

One of the challenges of public sector managed care is to address the complex needs of persons with serious and persistent mental illness (SPMI). Although many public sector providers are appropriately concerned that application of private sector managed care treatment restrictions may adversely affect treatment of persons with SPMI, managed care also offers the opportunity for both *programmatic* and *reimbursement* flexibility that in some cases may enhance services to persons with SPMI. The best examples of this have occurred in the development of capitated funding projects for provision of integrated services to this population. This chapter outlines the basic conceptual framework for such a project, a comprehensive, multi-level, integrated services system (ISS) designed to provide long-term treatment and rehabilitation services on a capitation-basis to persons with SPMI.

Because of the capitation method of reimbursement, project managers have the flexibility to design a system that more closely approximates an ideal ISS, without restrictions imposed by fee-for-service reimbursement constraints.

PROGRAMMATIC ISSUES

What are the programmatic requirements of an "ideal ISS"? From a historical perspective, early efforts to provide community-based services to persons with SPMI were facilitated on a national level by the development of the Community Support Program (CSP) in 1978 by the National Institute of Mental Health (Turner & TenHoor, 1978). The CSP described specific functional components necessary for a successful treatment system for persons with SPMI and served as the model for development of many community systems.

Over time, research has increasingly focused on two major elements of such systems as contributing to success: *psychosocial rehabilitation technology* (outpatient and residential) and *intensive case management.*

PSYCHOSOCIAL REHABILITATION TECHNOLOGY

Recent advances in psychiatric and psychosocial rehabilitation technology suggest that persons with SPMI can benefit from specialized treatment systems designed to optimize the potential for improved functional and quality of life outcomes. While the specific mechanisms that produce improved outcomes remain elusive, community-based psychosocial programs have been demonstrated to be more effective than traditional methods of treatment (Brekke, 1988). The ISS described below relies on fundamental psychosocial concepts (Bachrach, 1992), which were operationalized in community-based programs involving residential treatment, supported housing, clubhouses, case management, and the integrated services agency model. Several specific programs which have incorporated these concepts serve as model program components for the ISS.

In their evaluation of a psychosocial residential treatment facility, Hawthorne, Fals-Stewart, and Lohr (1994) found dramatic reductions in hospitalization, significant increases in employment, and significant decreases in homelessness. Clients who graduated from the program were referred to as "alumni" and were closely followed and supported in the community. The study compared outcomes for the year following discharge from the program with the one year mean of the two-year period before admission.

In contrast to the residential treatment model where clients are required to move to more or less supervised housing options, Shern, Surles, and Waizer (1989) describe a supported housing model which emphasizes the importance of permanent housing. In this model, needed support and treatment services for persons with SPMI are designed and provided for the client in the client's home.

Many clubhouse programs have been modeled after the Fountain House program in New York (Beard, 1982; Rosenfield & Neese-Todd, 1993) and emphasize client empowerment and vocational opportunities. Individuals involved in clubhouse programs are considered members, rather than patients or clients.

INTENSIVE CASE MANAGEMENT

A substantial amount of research has demonstrated the utility of intensive case management (ICM) in facilitating continuity, reducing service fragmentation, making appropriate services available, and providing a trusting, consistent relationship for the client with SPMI (Stein & Test, 1980; Intagliata, Willer, & Ergi, 1986). ICM has repeatedly been shown to decrease psychiatric and non-psychiatric hospital use (Bond, Miller, Krumwied, & Ward, 1988; Lipton, Nutt, & Sabitini, 1988; Borland, McRae, & Lycan, 1989). When applied to the "frequent user" sub-population, the method was found to reduce use of emergency psychiatric hospital services and to produce overall cost savings (Quinlivan, Hough, Crowell, Beach, Hofstetter, & Kenworthy, in press). Despite these promising findings, long-term outcome data documenting improved quality-of-life and functioning are scarce. A recent study by Hough et al. (in review) compared intensive case management services with more traditional intensity case management. While clients in both conditions showed less use of hospitals, improved functioning and improved self-perception of quality-of-life over 18 months, no evidence of greater effect in the intensive case management group was found.

Although clearly advantageous, ICM is not always successful in addressing problems associated with fragmentation or lack of coordination of services within the mental health care delivery system. Case management must usually rely on the voluntary cooperation of other providers. Consequently, it may be difficuft to bridge the "gap" created when providers operate with a sense of client "ownership" and the client has multiple providers. Even the best case managers may have difficulty negotiating continuity into a mix of services such as outpatient, socialization or day treatment services, a residential facility or supported housing program, and an occasional hospital episode. Further, fragmentation within the existing system can inadvertently complicate transitions between levels of care.

ICM clinicians also encounter fragmentation that exists between the mental health system and other involved service systems. Hough (in review), for example, found that the largest proportion of case manager time was spent facilitating client access to and use of social service, housing, criminal justice, alcohol and drug, and mental health systems. These and other forms of fragmentation and lack of coordination can unintentionally produce barriers rather than optimize opportunity for clinical, functional, and quality-of-life improvements for clients. Given the advances we have seen in psychosocial rehabilitation technology, it seems reasonable to attempt to achieve far more than reduction in hospitalization and cost savings to the system.

REIMBURSEMENT ISSUES

Problems associated with fragmentation can be compounded by variations in reimbursement mechanisms. Often, the type and frequency

of service are influenced by the reimbursing or funding organization. Community-based program services, for example, are generally not reimbursed by third party payers. On the other hand, more traditional providers tend to orient services toward what is reimbursable rather than toward what may optimize outcome potential for persons with SPMI (Reed & Babigian, 1994). While these issues can exert considerable influence on the design and delivery of service, they are based in the mechanics of reimbursement and not the needs of persons with SPMI.

CAPITATION

Given this dilemma, capitated payment has been identified as a possible solution. Despite early misgivings about capitation-based payment systems being used only to control costs (Bloom et al. 1994), there is growing evidence that capitation may also provide a viable method of addressing problems of fragmentation and lack of coordination (Lehman, 1987). While capitation does not automatically address fragmentation, Lehman (1987) specifies that capitation systems may increase flexibility and offer new configurations of services that are better coordinated and less redundant. Capitation, for example, can allow payment to be made for what the clients need when they need it, such as stable housing, which is not usually covered in conventional systems of reimbursement. Also, problems of client "ownership", limiting case management access, multiple providers and treatment plans, can be mitigated by careful engineering at the treatment planning stage. Case managers have considerably more leverage in the mix of providers if they control payment and are required to authorize services. Lehman (1987) suggests that everyone, whether individual providers or agencies, is required to relinquish some autonomy in order to achieve integration of services. The advantages and importance of a single point of responsibility for client care has been emphasized and documented in the literature (Hu and Jerrell, 1991; Shern, Surles, & Waizer 1989).

Capitation-based systems have recently been initiated in a number of states. In their review of the literature on these systems, Bloom, Toerber, Hausman, Cuffel, and Barret (1994) describe various methods used in the design of capitation-based systems established in Pennsylvania, New York, Minnesota, Arizona, California, Colorado, Rhode Island, and Utah.

Another approach to fragmentation is reported by Hargreaves (1992) in his discussion of the Integrated Services Agency (ISA) model in California. In 1988, the California Legislature created capitation-based funding for two ISAs designed and operated specifically for persons with SPMI. These ISA programs have *no restrictions on the use of funds*, but are responsible to provide or pay for *all* mental health services to clients. This arrangement allows for a high level of creativity and flexibility in the provision of services, yet maintains ISA accountability.

Similarly, in Los Angeles County, California, another approach has been implemented, based on the ISA model and incorporating both psychosocial and capitation principles. The Los Angeles County Department of Mental Health has applied this model on a capitation basis to "high utilizers" of the public mental health system. Capitation-based contracts have been executed with community-based provider organizations in several regions of Los Angeles County. These organizations are paid on a capitation basis and are responsible to provide, or pay for, all mental health services required for the client (See chapter by Barbour, Floyd, and Connery).

SYSTEM OVERVIEW

Aspects of each of the program models discussed above are incorporated into the integrated servicer system (ISS) presented, although the integrated services agency (Hargreaves, 1992) and the intensive case management model (Quinlivan et al., 1995) discussed above are more influential. The discussion presents a basic managed-care system comprised of an array of flexible and integrated services. The ISS can be successfully designed into an existing case management system or can be used in conjunction with contracting private services. However, designing an effective system to produce improved outcomes will likely require more than augmented case management or a central authority (Reed & Babigian, 1994; Talbott, 1995). Accordingly, certain system components, which are considered important to the effective functioning of the system, are presented, although, as Bachrach (1992) has pointed out, the underlying psychosocial principles are the most important aspect.

The following discussion is therefore not intended to present the "right" or only way to design and operate a capitation-based system for persons with SPMI, but rather to present some basic guidelines and ideas that we hope will be useful in designing a system customized to the local needs of a community.

The process of planning, designing, and implementing a system for persons with SPMI may best be undertaken in cooperation and collaboration with representatives of local providers, client advocacy groups, and family members. Involving these groups at the planning level will add important and useful perspectives to the design of the system. It will also help to insure a higher level of cooperation and may help overcome resistance from some, such as hospital providers, who may not benefit financially as much as under the traditional reimbursement system. Unlike most forms of payment, capitation can offer the opportunity to share risks and benefits with subcontracted providers. Involving other providers at the planning stage can help to align system goals and facilitate system integration. This planning process will also help ensure that the system is customized to local needs. As Bachrach (1992) has pointed out, a system cannot be "canned" and simply exported to different communities without carefully evaluating and addressing

the cultural, social, and economic aspects as well as the unique needs of each community.

SERVICES

Operationally, the ISS relies primarily on a clinical case management model, with application of a psychosocial rehabilitation philosophy. The most important aspect of the ISS is the relationship between the client with SPMI and the staff of a multi-disciplinary team. The team should include the disciplines of psychiatry, psychology, nursing, and social work, as well as specialists in dual diagnosis/substance abuse treatment, and peer counseling. The importance of including state-of-the-art psychiatric involvement on treatment teams has been emphasized as a major factor in seeking improved outcomes (Talbott, 1995). Paraprofessionals and volunteers were found to be particularly helpful in a study comparing the cost-effectiveness of several case management approaches (Hu & Jerrell, 1991). Selected family members as well as clients with SPMI should also be considered for inclusion as team members. The usefulness of family members in a case management system has been documented by Intagliata, Willer, and Egri (1986). Quinlivan and his colleagues (in press), in an intensive,case management program for treatment of "frequent users", demonstrated that selected clients can be effective and helpful as counselors, particularly in working with the more severely disordered clients. The team should also provide or have direct access to other services, such as individual, group, and family counseling and psycho-educational services, vocational services including supported and competitive employment opportunities, educational, and medical services. Linkage with primary care providers, including emergency care should be established as an integral component of the ISS. Similarly, linkage should be established with other systems that may be involved with clients such as drug and alcohol, social services, and criminal justice.

While all members of the case management team should know every client served by the team, one team member will have a more primary and close relationship with each client. We will refer to this team member as the personal service coordinator (PSC). The PSC becomes counselor, friend, collaborator, and advocate of the client as well as the coordinator of care. These relationships are intended to continue indefinitely as determined by the client. Previous clients should always be welcome to return if and when they feel the need. In order to achieve such a relationship, it is important for the case management team members to genuinely like and thrive on working with these clients. It is also of central importance for staff, at all levels of the organization and of all disciplines, to share a philosophy that is consistent with the principles of psychosocial rehabilitation as discussed by Bachrach (1992). Case management teams, particularly PSC staff, should also be culturally competent and able to communicate in the preferred language of the client.

The client and the PSC collaborate on the development of the personal service plan, which is created individually for each client. Each client must be seen as a unique individual, not just as a member of the SPMI population.

Case management teams should be based where they will be most accessible to clients. Each team coordinates the delivery of all services to the clients in its service area. PSC staff should carry a pager or cell phone and be available on a 24-hour basis. Also, an 800 phone number may be a helpful option, allowing toll-free access to the system by clients, their families, other providers, and the community on a 24-hour basis.

Enrollment into the ISS system can be accomplished by marketing the service directly to clients with SPMI. Statutes and regulations relative to enrollment in prepayment plans may vary from state to state and must be carefully reviewed before deciding on a specific enrollment method.

At the time of enrollment, a comprehensive psychosocial and physical assessment should be conducted. At the same time, a crisis intervention and emergency plan should be developed for each client with input from the PSC and family members or other individuals with significant involvement in their lives. By doing this during a time when the client is not in crisis, the client and his/her significant others, as well as the case management team, will be better prepared if a crisis does arise.

PSC staff should maintain regular and structured contact with clients. At the time of enrollment, contact may need to be frequent. With less stable clients, daily contact may be indicated. Occasionally, for short periods, contact may actually be continuous until appropriate arrangements can be made to ensure client safety. On the

Survival Tips
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The importance of financial and clinical systems integration and the importance of the client's perspective in the design and operation of the system cannot be overemphasized.

other hand, some more stable clients may find frequent contact to be unnecessarily stressful and may request less contact. Tailoring services to individual needs is a key component of the ISS.

SYSTEM COMPONENTS

Integration of Services In a Capitated System

Operational integration of services in the capitated ISS is a centrally important concept. Whether services are provided directly by ISS staff, or by sub-contract, the case management teams will serve to integrate the system components. Integration will be facilitated not only by careful clinical management, a close working relationship between the case management team and the other ISS or sub-contracted providers, and a high level of collaboration between the clients and the case management team, but also by direct control of reimbursement for all service components.

In addition, integration will be further facilitated by the design of subcontractual arrangements with outside providers. Whether subcontracting is by case-rate, fee-for-service, or sub-capitation, the case management team should design and manage the level and intensity of services. This can be accomplished in a number of ways. The role of the case management team could be expanded to include authorization of services, or, they could have a more advisory role wherein authorization and payment decisions would be made further up the administrative ladder. Particularly in larger public systems, contractual relationships are managed at an entirely different level than that of the client and the case management team. Nonetheless, efforts should be made to link these controls more directly to the operational level of the client and case management team.

These contractual arrangements are an important aspect of integrating services and also represent one of the major departures from more traditional case management systems. Most case management systems rely on the voluntary cooperation of other providers in the system, which can vary considerably. Property engineered capitation systems tend to focus and align the goals of system providers. By design, system providers are working toward the goal of helping each client become as functional and as independent as possible. Careful management of resources and an emphasis away from more expensive and intensive services such as hospitals can benefit both the client and the system.

However, this shift in reimbursement systems may also introduce ethical considerations of a different nature than those generated within fee-for-service reimbursement systems. While capitation can offer increased flexibility and creativity which may facilitate improvement in clinical, functional, and quality-of-life outcomes for the client with SPMI, there are no guarantees. As fee-for-service systems tend to be abused by over-utilization of services, so capitation-based systems lend themselves to abuse by failure to provide needed and necessary services and resources. Because most capitation systems

are population based rather than service based, the provider receives payment regardless of whether or not a client receives services. This arrangement provides little incentive to seek out difficult clients with SPMI, particularly those who are homeless and may not seek services on their own. The prospect of incurring increased costs for emergency care at some point in the future may not always be an adequate deterrent, especially in the short run.

Case-rate payments, which are service based instead of population based, may provide a viable option in this instance. Specific services, such as hospitalization, are reimbursed on a negotiated rate per episode, regardless of length of stay. The arrangement may also include a form of warrantee, which requires the hospital to provide free or discounted readmissions within a specified time period. Case-rate payments can therefore offer an incentive to seek out and serve clients who may otherwise go without, and an incentive to provide quality services by linking the service to the outcome.

An array of integrated system components or levels of care should be available in the ISS. These should include at least the following: psychiatric hospitalization, including involuntary detention; a hospital alternative/diversion program (See chapter by Hoge, Davidson, and Sledge); transitional and/or longterm residential treatment facility; a clinic, day-treatment, or partial hospitalization program, a clubhouse program, day rehabilitation and socialization services, in-home mental health care, money management, and housing assistance.

Psychiatric hospital services, particularly locked beds, are essential. The case management team psychiatrist should have admitting privileges at the hospital where a client will be admitted if hospitalization is necessary. This will allow for continuity in the client's treatment and continuous involvement of the case management team who will determine the treatment and the length of stay actually necessary in a hospital setting.

Residential treatment services include structured long-term and/or transitional residential treatment facilities for clients who are not stabilized enough to function without on-site staff on a 24-hour a day basis. These residential programs are housed in normal residential neighborhoods, usually in large single family homes, or small remodeled apartments housing from eight to twelve clients. They are designed to provide a supportive treatment setting for clients who are at high risk for hospitalization, and/or who have experienced repeated failures at attempts to live in the community, even with a high level of staff support. The programs are not presented as a place to live indefinitely, but as a place to learn how to live in the community. This level of care may be particularly useful for reintegration of long-term or State Hospital clients back into the community.

Inclusion of a clubhouse type program can serve as the vocational component of the ISS. It can include the operation of supported and competitive employment opportunities as well as house client operated businesses. For example, a clubhouse could actually be the hub or centerpiece of the ISS system with an array of services provided on site. On the other hand, for some communities, the ideal

clubhouse may be entirely client operated and simply supported financially by the ISS.

The availability of housing assistance has been demonstrated to be beneficial in the treatment of persons with SPMI (Talbott, 1995) and is considered an essential component of the ISS. Housing can include living independently in an apartment, an independent living facility, or living with one's family. Housing can also be provided in multiple-unit apartment-type buildings. These housing resources may also be comprised of smaller residential units and/or duplex units and should be located in areas where clients have access to services and public transportation. They can be leased by the ISS or can be provided by sub-contract. The most important issue is that these housing resources are made available for clients to rent.

The ISS should be able to eliminate hospitalizations due to problems associated with lack of housing for its clients. Hospitalization can occur simply because a client decompensates when he or she has no money and no place to stay. Often, clients are unable to independently rent an apartment simply because they do not have the required security deposit, first and last month's rent, and the fee for a credit check. This arrangement will allow clients to rent apartment units without these often preclusive cash requirements. Clients can establish a credit history as a tenant by renting from the ISS. Clients who require temporary hospitalization or admission to other more restrictive levels of care would not risk losing their apartments as a consequence.

The PSC should have the flexibility to provide services to the client in his or her home whenever that level of care is most appropriate. Such interventions can sometimes prevent decompensation and reduce the "drop-out" factor from the ISS.

OUTCOME RESEARCH/QUALITY IMPROVEMENT

The use of process and outcome measures to monitor and improve program effectiveness is becoming widespread. Improvement in the outcome of care should be as important as financial considerations in the operation of the ISS system. Failure to link outcomes to the operation of a system can be a costly omission (Reed & Babigian, 1994). It is particularly important in a new system implementation to carefully design an outcome measurement system to provide feedback on provider and system performance. The ability of the ISS to measure and link the outcome of care to system/provider operation is crucial to the successful operation of the system. An effective evaluation system will provide benchmarks from which efforts to improve the quality of services for persons with SPMI can be measured (See chapter by Essock and Goldman).

In concluding our discussion of a system of treatment and rehabilitation for persons with SPMI, there are two centrally important factors that should be emphasized and serve as guiding principles in the process of design. One is the importance of financial and clinical systems integration. A properly designed, capitation-based pub-

lic sector managed care system can offer integrated, high utility, and cost-effective services within a framework that allows creativity and flexibility.

The importance of the client's perspective in the design and operation of the system is another factor that cannot be overemphasized (Anthony et al., 1988; Marlowe, & Marlowe 1983). In order to maximize opportunities for clients with SPMI to achieve and sustain substantive clinical and functional gains, as well as improvement in their quality of life, the system must be designed to meet the client's needs, and not the needs of the system.

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