III. Discussion and Recommendations

A number of organizational and practice parameters are useful in describing and comparing case management interventions. Burns, Gwaltney, & Bishop (1995) articulated a set of organizational parameters for case management models: the case manager-to-client ratio, the frequency of contact between case manager and clients, and the duration of the service. Practice parameters of case management include the variables of focus of services, availability of service, the site where services are offered, and the amount and nature of client direction offered in the care coordination model (Willenbring, Ridgely, Stinchfield, & Rose, 1991). **Table 5** describes these parameters for each care management approach described in this volume.

Table 5.

Comparison of Case Management Parameters by Models

Care Management Model	Caseload Size	Number of Contacts	Duration	Focus	24/7	Site	Client Direction
Child and Family Teams	12-15		14-15 months	Child and Family	Yes	Community	Family directed
Coordinated Family Focused Care	10 Served by 2 people	Flexible	Flexible	Child and Family	Yes	Community	Family directed
Continuous Treatment Teams	6	12 contacts/ month	Flexible	Child and Family	Yes	Community and Office	Family and team directed
Wraparound Milwaukee	9	15–16 hours/ month	Flexible	Child and Family	Yes	Community	Family directed
Dawn	8-9	14 hours/ month	14-15 months	Child and Family	Yes	Community	Family directed

Caseload size and number of contact hours per month are proxies for the intensity of the care management model. As shown in **Table 5**, the caseload size ranges from a high of 15 children to a low of six, with most models serving between 8–10 children. At least two models (Continuous Treatment Teams and Wraparound Milwaukee) specify the amount of contact that is expected by the care manager with the family each month. Regarding the length of stay, most models do not specify an upper limit. Rather, the length of stay is flexible and based on the needs of the individual child and family. Fourteen to fifteen months is the average length of stay for Child and Family Teams in Maricopa County and the Dawn project.

All the models clearly state that the focus of care is the child within the context of the family, and that services are available 24 hours a day, seven days a week. Regarding the degree of client direction, four of the five models appear to be in the forefront of offering family driven care, defined as care where families have a decision-making in the role in the treatment of their children. Family driven has been described as: “This includes choosing supports, services,

and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining effectiveness of all efforts to promote the mental health of children and youth" (US Department of Health and Human Services, 2005 p,16). Finally, all models are guided by the principle of community-based, with most services being offered in the home and community.

Policy and Practice Recommendations

Some interviewees across sites noted the need to begin with the development of a shared vision and set of principles, before the operational planning for care management. The visioning process can result in an agreed upon conceptual framework, such as a resilience model for children with serious emotional problems. The framework can then serve as the basis for the case management model. For example, the use of a strengths-based approach is very useful with families because it emphasizes what they are already doing well. Another suggestion was to emphasize the importance of communication and teamwork in the implementation of an intensive case management model.

Several recommendations relate to the organizational and program requirements that must be developed for a new care management program (Evans & Armstrong, 2002) is that the care management model needs to be well specified, with clearly defined job descriptions. A related decision is who will provide the care management. Wraparound Milwaukee and ValueOptions decided to contract out the care coordination process to a variety of community agencies. An advantage of this approach is the ability to include culturally diverse and indigenous community agencies. However, the providers must agree and be able to make arrangements so that care coordinators and family partners have flexible hours and working arrangements.

The planning process for implementation of a new care management model should be comprehensive, laying out a set of sequential steps that need to take place at all levels of the system, including the managed care entity, the state agencies responsible for behavioral health managed care, providers, and families and advocates. The implementation should be staggered so that unforeseen challenges can be addressed and resolved, rather than going to scale immediately. Start-up funds are essential, so that a full-scale training, coaching, and technical assistance plan can be carried out. The use of external resources for training and technical assistance can be useful. Finally, funds are needed for ongoing monitoring of the implementation of the care management approach.

Interviewees emphasized the need for a massive re-training effort, both of existing staff who will be re-assigned to the new care management approach, and of the system partners who serve these youth, including child welfare, juvenile justice, and education. In Arizona, child-serving system partners are regularly invited to attend Child and Family Team process training and coaching activities. The sequencing of training also is important; e.g. supervisors, clinicians, and out-of-home providers need to be targeted early in the training plan.

A related challenge is the need to educate the other child serving systems to the new care management process and driving principles. One site has shared crosswalks of the Child and Family Team process to congruent "best practice" approaches familiar to child welfare (e.g., family-group decision-making), developmental disabilities (personal futures planning), early childhood and juvenile justice partners; predicated on the incorporation of the same set of non-negotiables in those similar approaches, and with the assumption that behavioral health can simply "join" such existing processes instead of forming a new Child and Family Team where, in essence, one already exists.

Sequencing is also important in the recruitment, training, and hiring of direct service providers, such as respite caregivers and behavioral health aides, so that these resources are readily available as the needs are identified in service plans. The process of developing new service modalities is ongoing; in Milwaukee, for example, the provider network of community agencies currently offers families a choice of 80 different services.

Interviewees from several sites noted the challenge of recruitment and retention of care managers and family partners. One goal of Wraparound Milwaukee, for example, is to recruit Care Coordinators who are more mature and experienced in children's services. Their perception is that a new care coordinator's lack of experience can be an impediment in forming strong and trusting relationships with families.

Another challenge is to develop policies and procedures that monitor fidelity to the new care management process, and the related need for fiscal resources for training, coaching, and other quality assurance, quality improvement, and evaluation mechanisms. Some interviewees noted that the level of fidelity of the care management model varies across providers. Several sites emphasized the need for a standardized set of quality improvement supervision tools, and practice fidelity methods, including youth and family interviews with families and youth being served by the care management teams.

Some interviewees recommended that families who are being discharged could benefit from a transition step-down case management program so that the intensity of contacts could be gradually reduced.

For rural communities, telemedicine is a recommended vehicle for offering consultation and specialized assessments for children. AdvoCare has plans to offer this service to the Continuous Treatment Teams in the near future.

In the area of financing, one recommendation is for states to apply for a Psychiatric Rehabilitation waiver for Medicaid services. In comparison the Targeted Case Management, the waiver provides more flexibility in being able to offer creative service modalities, and to offer services in school and in communities.