

January 30, 2006

VHA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy regarding VHA's mental health intensive case management (MHICM) program for seriously mentally ill veterans, a part of the mental health continuum of care.

2. BACKGROUND

a. Severe mental illness, primarily psychosis, is a major problem among veterans. Fiscal Year (FY) 2004 Compensation and Pension (C&P) data indicate that 108,226 veterans are service connected for psychoses of which 56,773 used VHA services. According to the Department of Veterans Affairs (VA) National Psychosis Registry, over 217,760 veterans diagnosed with a psychosis used VHA services in FY 2004. The clinical literature suggests that approximately 20 percent of people with severe mental illness are in need of intensive community case management services. Data from State mental health agencies suggest that nationally 4.5 percent currently receive Assertive Community Treatment (ACT), the most well-known approach to providing intensive case management.

(1) This intensive interdisciplinary team approach to ambulatory management and treatment of persons in, and coordinated with, the community and its services, is clearly distinguished from usual case management by:

(a) Engagement in community settings of people with severe functional impairments traditionally managed in hospitals;

(b) An unusually high staff to client ratio; multiple visits per week if needed;

(c) Interventions primarily in the community rather than in office settings; and

(d) Fixed team responsibility, around the clock, for total client care over a prolonged period (see subpar. 2e(2)).

(2) Multiple studies, including three recent VHA studies, have shown that the intervention is cost effective, particularly where the service is offered to chronically ill, hospitalized patients and where the model is rigorously adhered to with respect to assertiveness of the intervention and maintenance of low caseloads. There is compelling evidence for the effectiveness of ACT with clients who experience psychotic symptoms, but its use may also be considered in severe and persistent affective disorder, post-traumatic stress disorder (PTSD), etc., where independent functioning is impaired. However, a FY 1998 survey by the Committee on Care of Severely Chronically Mentally Ill (SCMI) Veterans revealed that just over 8,000 veterans received some form of mental health team case management from VHA, and of those, only 2,000 met ACT

THIS VHA DIRECTIVE EXPIRES JANUARY 31, 2011

VHA DIRECTIVE 2006-004

January 30, 2006

Fidelity Measures criteria for intensive case management. Therefore, a gap in these state-of-the-art services is evident, resulting in unnecessary costs and patient morbidity to VHA.

b. The SCMI Strategic Implementation Committee considered various models of intensive case management within the mental health service arena, then defined intensive case management for veterans with severe mental illness in VHA and the accountability expected from this designated program.

c. Following issuance of VHA Directive 2000-034, VHA Mental Health Intensive Case Management (MHICM) a network planning process was initiated by NEPEC to stimulate implementation of MHICM services and monitoring of network implementation. NEPEC has produced quarterly reports to VA Central Office and to the Veterans Integrated Services Network (VISN) Directors along with a comprehensive annual report which documents adherence of each program to VHA policy, identifies outliers, and documents clinical outcomes using standardized measures.

d. MHICM is a cost-effective intervention given appropriate client selection in spite of the known resource intensity of the interventions. This efficiency (offset) results from avoidance of other costly interventions, such as: multiple or lengthy hospitalizations, extensive ambulatory clinic use, and visits to emergency rooms. *NOTE: Existing resources that previously supported inpatient care need to be shifted to support outpatient mental health services that foster a recovery process, such as MHICM teams.*

e. Definitions

(1) **Target Population.** MHICM programs are intended to provide necessary treatment and support for veterans who meet all of the following five criteria:

(a) Diagnosis of Severe and Persistent Mental Illness. Diagnosis of severe and persistent mental illness includes, but is not limited to: schizophrenia, bipolar disorder, major affective disorder, or severe PTSD. Mild to moderate organicity may coexist. Although the veteran may have a co-occurring alcohol or substance abuse diagnosis, this is not the primary problem for which treatment is required.

(b) Severe Functional Impairment. Severe functional impairment is such that the veteran is neither currently capable of successful and stable self-maintenance in a community living situation (e.g., hospitalized or homeless), nor able to participate in necessary treatments without intensive support. A Global Assessment of Functioning of 50 or less may be used to estimate the degree of impairment.

(c) Inadequately Served. The veteran is inadequately served by conventional clinic-based outpatient treatment or day treatment.

(d) High Hospital Use. High hospital use as evidenced during the past year by over 30 days of psychiatric hospital care, or three or more episodes of psychiatric hospitalization.

(e) Clinically Appropriate for Outpatient Status. Patients who are more appropriately managed clinically as inpatients need to remain in the inpatient setting; that is, the positive aspects of MHICM should not be used to justify moving veterans who would be better served by inpatient care to this ambulatory care model.

(2) **Description of the Program.** MHICM programs are delivered by an integrated, interdisciplinary team and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. There are four core treatment elements:

(a) Very Frequent Contacts between Care Givers and Veteran Clients. The treatment process includes two phases:

1. High intensity of care (typically two to three contacts per week) primarily through home and community visits, with low caseloads (seven to fifteen veterans per 1.0 clinical Full-time Equivalent (FTE) employee), allowing rapid attention to crisis, and the development of community-living skills to prevent crisis in this exceptionally vulnerable population.

2. Appropriate transition to lower intensity care. After one year of MHICM treatment, some veteran clients can be transferred to either standard care or to continuous treatment by the MHICM team at a lower level of intensity (e.g., typically requiring community contacts less than once per week). Characteristics of readiness for a lower-level of care include the following, clients are:

- a. Clinically stable;
- b. Not abusing addictive substances;
- c. Not relying on extensive inpatient or emergency services;
- d. Capable of maintaining themselves in a community living situation; and

e. Independently participating in necessary treatments. *NOTE: NEPEC monitors this transition through periodic clinical progress reports and reports both levels of intensity separately. No more than 20 percent of a MHICM team caseload should consist of clients receiving "low intensity care."*

(b) Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlord, employer).

(c) Focus on Rehabilitation. The focus on rehabilitation is through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care, independent living, and competitive employment where possible.

(d) Responsibility. Identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran, wherever the veteran happens to be, for a prolonged

VHA DIRECTIVE 2006-004

January 30, 2006

period. This responsibility is expected to last for a minimum of 1 year for all MHICM clients, but is subsequently based on a periodic review of continuing need for intensive services.

(3) Data Recording

(a) Decision Support System (DSS) Identifiers. Attachment A contains the definitions of the revised DSS Identifiers for the MHICM workload (546, 552, and 567) as well as the new code for general (non-intensive) mental health case management (564).

(b) The Office of Mental Health Services continues to work with the Office of Quality and Performance to develop performance indicators which may be used in the Executive Career Field (ECF) Performance Contract, such as the MHICM Capacity and Screening for MHICM in the FY 2005 contract.

(c) NEPEC continues to summarize, on a quarterly basis, data for each VISN indicating the ratio of MHICM-treated patients to those potentially eligible. *NOTE: VISNs may use these data to identify potential service gaps.*

3. POLICY: It is VHA policy to support the development of case management approaches sufficient to meet the need where appropriate; and MHICM programs need to be established out of existing or supplemental funds. *NOTE: NEPEC, which has developed and evaluated this type of program for 18 years, is providing the leadership for training and monitoring of new and established teams.*

4. ACTION

a. VISN Director. Each VISN Director is responsible for:

(1) Addressing population-based needs for MHICM services;

(2) Establishing strategies to provide their severely mentally ill veterans within the described target population (see subpar. 2e(1)) access to MHICM services sufficient to meet the need; and

(3) Supporting recommendations by NEPEC to maintain MHICM standards.

b. Office of Mental Health Services. The Office of Mental Health Services is responsible for:

(1) Assessing, deploying, evaluating, and disseminating quality and cost efficient best practices by utilizing NEPEC, Management Sciences Group, and Allocation Resource Center data and expertise and by collaborating with the Office of Quality and Performance (10Q).

(2) Overseeing the effectiveness of the MHICM program by monitoring, training, and evaluating, and by collaborating with the SCMI Committee to assess clinical and deployment outcomes and to recommend future actions.

(3) Ensuring completion, quality, and distribution of MHICM monitoring reports and the Annual National MHICM Performance Monitoring Report.

(4) Recommending to the Office of the Deputy Under Secretary for Health for Operations and Management (10N) any MHICM program that should be dropped from the MHICM program because of persistent inability to meet evidence-based fidelity standards or reporting requirements.

c. **NEPEC.** NEPEC is responsible for:

(1) **Monitoring and Training Actions.** Because MHICM is resource intensive and the participating veterans are vulnerable, the following monitoring procedures will be implemented under the leadership of NEPEC. *NOTE: Forms may be obtained at <http://vhaaacweb3.vha.med.va.gov/NEPEC/Main.asp>. Questions may be addressed to (203) 937-3850.*

(a) **Standard Intake Data Form (IDF).** Standard IDF is administered to all new admissions to MHICM. It documents adherence to the eligibility criteria and records baseline data on clinical status, functional impairment, and satisfaction with services. The IDF takes about 30 to 45 minutes to complete per veteran.

(b) **Follow-up Data Form (FDF).** Follow-up FDF must be administered at 6 months and at 1 year after program entry and annually thereafter. It consists of a subset of health status and community adjustment measures from IDF. The FDF takes about 25 to 30 minutes to complete per veteran.

(c) **Clinical Process Form (CPF).** A CPF documents delivery of MHICM service elements and must be completed by each client's primary case manager every 6 months after program entry. The CPF takes about 15 minutes to complete on each veteran.

(d) **MHICM Check List and ACT Fidelity Measure.** The MHICM Check List and ACT Fidelity Measure are to be completed by the program director once a year for the entire program. This form takes about 20 minutes to complete.

(e) **MHICM Team Annual Report.** Each team must provide monthly data on staffing and clients. At the end of the fiscal year, teams must summarize data for the preceding year in the form of an annual report, due on November 15th of each year. Data from team reports and checklists (see subpar. 4b(4)) are integrated by NEPEC in the National MHICM Performance Monitoring Report. The MHICM Team Annual Report is distributed VHA and VISN Directors, VHA and VISN Chief Medical Officers, VHA and VISN QMO Peers, and Mental Health Service Line Leaders. In addition, it is available on the NEPEC website at: <http://vaww.nepec.mentalhealth.med.va.gov> .

(f) **VHA Administrative Data.** VHA administrative data are used to track MHICM process and outcomes using inpatient and outpatient service utilization data available from the Patient Treatment File and the Outpatient Care File in the Austin Automation Center.

VHA DIRECTIVE 2006-004

January 30, 2006

(2) **Oversight.** Oversight is provided to all MHICM programs to ensure that standards are met through periodic site visits to treatment teams, regular national meetings of team leaders, conference calls, consultation, and national training programs. Programs systematically not meeting standards may be decertified from using the MHICM DSS Identifiers, after consultation with MSHHG.

(3) **Integration.** Data collection must be integrated into standard VA computerized data systems, providing sites with spreadsheet summaries of national and site-by-site program results on a regular basis, and providing clinicians with client-specific output for clinical review.

(4) Reports

(a) Periodic annual reports on the structure, process, and outcomes of MHICM services must be produced for training programs in evaluation and clinical procedures. These are available in bound version as well as electronic files and available for download on the NEPEC Intranet (<http://vaww.nepec.mentalhealth.med.va.gov>) and Internet (<http://www.nepec.org>) webpages.

(b) Reports on VISN-level population-based needs for which it is necessary to work with the Office of the Assistant Deputy Under Secretary for Health and the Serious Mental Illness Treatment, Research, and Evaluation Center (SMITREC).

(5) **Communication.** Facilitating ongoing communication and linkage among programs across the country is facilitated through monthly conference calls and up-to-date email groups.

(a) VISN and VA facility-level leadership must be informed where standards are problematic and there is a need to recommend actions to strengthen the MHICM teams.

(b) MSHHG leadership must be informed of MHICM programs that are persistently unable to meet the evidence-based ACT fidelity standards. **NOTE:** *If the standards are not being met, consideration should be given to dropping them from the program and no longer allowing them to use the MHICM stop codes.*

d. **Facility Director.** The facility Director is responsible for:

(1) Utilizing national DSS identifiers to designate MHICM activity.

(2) Providing complete nationally-adopted monitoring information for MHICM in a timely manner.

(3) Maintaining team fidelity to program operating principles (see subpar. 2e(2)) and adhering to evidence-based clinical procedures.

(a) Adequate resources are needed to provide a critical mass of staff to comprehensively address the needs of these exceptionally vulnerable patients, even in the face of staff turnover and other absences.

VHA DIRECTIVE 2006-004
January 30, 2006

(b) At least four clinical FTE employees are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA medical center that can provide 24-hour coverage and emergency services. At sites where there are insufficient patients to justify a full team, consideration is to be given to partnering with the community, e.g., existing ACT teams. ***NOTE:** A model for rural MHICM teams where there is not a sufficient patient base for a full MHICM mode, is being developed.*

(4) Providing transportation (i.e., General Services Administration (GSA)-leased vehicles) and electronic communication technology resources (i.e., cell phones, laptops, etc.) to facilitate safe and efficient delivery of community-based services.

5. REFERENCES: See website at: <http://vaww.mentalhealth.med.va.gov/MHICMRef.shtm> for current clinical references.

6. FOLLOW-UP RESPONSIBILITY: The Deputy Chief Patient Care Services Officer for Mental Health (116) is responsible for the contents of this Directive. Questions may be directed to 203-937-3850.

7. RESCISIONS. VHA Directive 2000-034 is rescinded. This VHA Directive expires January 31, 2011.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

Attachment

DISTRIBUTION: CO: E-mailed 2/01/06
FLD: VISN, MA, DO, OC, OCRO, and 200 - E-mailed 2/01/06

ATTACHMENT A

DECISION SUPPORT SYSTEM (DSS) IDENTIFIER (STOPCODES) FOR MENTAL
HEALTH INTENSIVE CASE MANAGEMENT

Decision Support System (DSS) Identifier Number	DSS Identification Name	DESCRIPTION
546	TELEPHONE MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next-of-kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the special MHICM teams (see 552). Includes administrative and clinical services. <i>NOTE: The patient's health information and treatment plans may only be discussed with individuals, such as next-of-kin, who are involved in the patient's care. Patient health information and treatment plans containing records which reveal the identity, prognosis, diagnosis, or treatment of Department of Veterans Affairs (VA) patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, have additional protections under Title 38 United States Code 7332 and may not be released or discussed even with individuals who are involved in the patient's care unless there is written authorization from the patient.</i>
552	MHICM	<u>Only VA medical centers approved to participate in MHICM programs monitored by Northeast Program Evaluation Center (NEPEC) may use this code.</u> This records visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided to MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
567	MHICM GROUP	<u>Only VA medical centers approved to participate in MHICM programs monitored by NEPEC may use this code.</u> This records group visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
564	MENTAL HEALTH TEAM CASE MANAGEMENT	Records visits with patients and/or their families or caregivers by members of a mental health case management team performing mental health community case management at all locations.

VHA DIRECTIVE 2006-04
January 30, 2006

	Includes administrative and clinical services provided to patients by team members. (<u>NOT</u> to be used for visits by MHICM teams [see DSS Identifier #552], or for case management by individuals who use other stop codes.)
--	---