

Roger G. Kathol
Katherine Hobbs Knutson
Peter J. Dehnel

Physician's Guide

Understanding
and Working
With Integrated
Case Managers



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Roger G. Kathol, MD
Adjunct Professor
University of Minnesota
President, Cartesian Solutions, Inc.™
Burnsville, MN, USA

Katherine Hobbs Knutson, MD, MPH
Medical Instructor
Department of Psychiatry
and Behavioral Sciences
Duke University School of Medicine
Durham, NC, USA

Peter J. Dehnel, MD
Medical Director for Case Management and
Utilization Management
Blue Cross Blue Shield of Minnesota
Edina, MN, USA

ISBN 978-3-319-28957-1 ISBN 978-3-319-28959-5 (eBook)
DOI 10.1007/978-3-319-28959-5

Library of Congress Control Number: 2016937530

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Printed on acid-free paper

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Foreword

Improving the outcome for patients in our sophisticated healthcare systems is not straightforward. Many health service research studies have negative results on the patient level, and those who have positive results often cannot be implemented on a large scale. This is specifically true for comorbid complex patients.

An explosion of medical knowledge has led to a dramatic expansion of separate domains of knowledge and competencies, but many of these do not understand or communicate with each other. This has resulted in the fragmented care for patients with both medical and behavioral health complexity. And yet we know that outcomes for patients with complex health needs are related to the level of integration achieved with the care provided.

There are several ways to increase integration within healthcare systems. Most are implemented at the organizational level. However, successful programs typically have similar conceptualizations of triage, the approach to collaboration of care, and the roles that various healthcare contributors make. This is true at both the system and the care delivery level.

Regardless of what is done at the system level, quality of care starts with the relation between the patient and the healthcare professional. Crucial in such a professional relationship is communicating about needs and goals. This is the common ground for every complex treatment plan and outcome-changing follow-up care. At the center are the goals that matter to the patient, but these must coincide with goals inherently developed by healthcare professionals.

The beauty of the Integrated Complex Case Management (ICM) concept is that it uses the Integrated Case Management-Complexity Assessment Grid (ICM-CAG) as a fundamentally versatile tool to improve and standardize the core process of communication between patients and their physicians, whether they are part of a hospital team, a primary care clinic-based team, or a network of health professionals and treatment facilities involved in the patient's care.

Patient-centered collaboration is what we are all trying to achieve. Unfortunately, from more than 30 years of clinical experience and research, it is far from easy to make patient-centered collaboration work in real life. The vast amount of information about concepts and evidence related to this topic expressed in this book,

combined with the authors' personal experiences as clinicians, researchers, teachers, and consultants in healthcare innovation, could have saved me 10 years of struggling had I read it 30 years ago.

I am confident that many leading physicians who are struggling to better organize the delivery of care for the health system's most vulnerable and difficult patients in pediatric or adult practice will benefit immediately through the clear guidance, from theory to practice, described in the *Physician's Guide: Understanding and Working with Integrated Case Managers*.

Groningen, The Netherlands

Joris P.J. Slaets
Department of Medicine
University Medical Center Groningen

Preface

It is well established that healthcare spending in the United States is unsustainable. In the United States, we spend over 17% of gross domestic product on healthcare, and many states are struggling to maintain adequate revenue for vital services such as public education due to encroaching healthcare spending. We also are well aware that the quality of the healthcare provided for these exorbitant costs is lacking. The United States ranks 27th in life expectancy among the 34 OECD countries, and health outcomes are particularly poor for minority populations and those with social disadvantage.

There have been many efforts to address issues related to the high cost and poor quality of the US healthcare system. Targeted interventions, such as use of generic medications, and preventive measures, like vaccines, have demonstrated cost savings while maintaining or improving quality. The emerging role of technology in healthcare holds promise for improvements in health with reductions in cost. Perhaps one of the most robust health system changes that may address the cost/quality chasm is aligning payment and clinical delivery systems while holding these systems accountable for health measures across the population. Such Accountable Care Organizations, or ACOs, may shift the focus of healthcare toward lower cost population-based interventions, as opposed to procedures and treatments that increase revenue for the medical system but offer little in terms of health improvement.

Those who are responsible for paying for healthcare recognize that individuals with a high burden of medical and psychiatric disease tend to engage with the medical system in a cost-ineffective manner. Adding in vulnerabilities such as poverty, homelessness, and limited education contributes to even higher medical spending and often related poor health. Our current healthcare system imposes significant complexities and barriers, such as limitations in health insurance coverage and logistical challenges in accessing needed treatments. Further, socially disadvantaged individuals with combined medical and psychiatric disease are often the ones who struggle the most to navigate such a complicated health system. To lower healthcare spending through improved health, there must be a comprehensive approach to addressing the needs of this vulnerable population.

Integrated case management (ICM) was developed by the INTERMED group in Europe and has been adapted for use within the US medical and payment systems. ICM provides a systematic method for identifying and addressing the needs of patients in multiple domains: biological, psychological, social, and health system related. Through ICM, case managers are educated to conduct comprehensive assessments with a combined focus on fact gathering and relationship building with patients.

Following this initial evaluation, the ICM tools facilitate the categorization and scoring of multi-domain vulnerabilities. From this distillation of the patient's biopsychosocial and health system profile, patient-centered and healthcare system-related goals are identified, and actions required to achieve these outcomes are described. Progress is monitored as case managers work with patients and clinicians to complete action items and achieve stated goals. ICM has the benefits of being easily interpreted and understood by practitioners and patients alike, providing use in both clinical and payment settings, and being available for adult and pediatric populations.

In this era of focus on population health outcomes and healthcare costs, physician leadership is vital. Physicians need to make clinical decisions that apply directly not only to the medical care they are providing but also to the upstream environmental and social factors affecting the health of the population they serve. Physicians must recognize that they are unable to tackle both of these initiatives without the support of other clinical and non-clinical staff, and physicians need to build health systems that embrace these concepts of interdisciplinary teamwork. Finally, physicians are in a prime position within the healthcare system and their broader communities to build relationships across agencies that support prevention and a path toward health.

This book was written to help physicians understand the importance of addressing the needs of patients who present with combined poor health and high healthcare-related costs, as well as the nature of working with others within and outside of the medical field to improve outcomes. The nuts and bolts of ICM will be described, as well as the concrete issues to consider when implementing an ICM program into a clinical and/or payment system. The rationale for how ICM contributes to value enhancement and methods for demonstrating its success are introduced. Ultimately, this book provides a guide to increasing the effectiveness of physicians working with case managers, both as leaders and as partners in clinical care.

As such, this book may be used to learn about concrete aspects that assist and support professionals delivering integrated case management and to imagine and foster the development of a healthcare system that works. A healthcare system where actions and outcomes are aligned to improve healthcare quality and the multiple areas that contribute to poor outcomes—both within and outside the healthcare system walls—are addressed in a proactive and comprehensive manner. In such a system, patients may become healthier with improved satisfaction in their medical

care, thus reducing their need for costly interventions and lowering overall health-care use. By realizing these individual changes person by person throughout a population, we may seamlessly correct our current unsustainable trajectory through substantial reductions in cost with simultaneous improvements in health.

Burnsville, MN
Durham, NC
Edina, MN

Roger G. Kathol, M.D.
Katherine Hobbs Knutson, M.D., M.P.H.
Peter J. Dehnel, M.D.

Acknowledgments

This work could not have been completed without the support and encouragement of the authors' families and work colleagues. Dr. Kathol especially wishes to thank his wife, Mary Kathol M.D., for her forbearance in putting up with his long hours in the office writing, compiling, and collating content included in the book. Further, he wishes to express appreciation for her professional feedback on content, direction, and organization. Her background in medical education led to the addition of many aides to understanding the message found in the book.

Dr. Kathol also wishes to acknowledge support provided by the Case Management Society of America (CMSA) and especially Cheri Lattimer, the organization's Executive Director, for assistance in reviewing materials and charting direction for case management as a whole as it takes its place in a reformed healthcare environment. Danielle Marshall, Chief Operating Officer for CMSA, provided innovation in the form of lexicon development for case management as a part of CMSA's e4 program. Through her work, and that of Task Force team members Kathleen Fraser, Mary McLaughlin-Davis, Nancy Skinner, Betsy Clark, Danielle Marshall, and Cheri Lattimer, it was possible to better clarify terminology that could be used to advise physicians in core concepts about patient "assist and support" services that is central to case management.

Dr. Joris Slaets, a geriatrician, wrote the Foreword. While he has been a major contributor to development and research related to the INTERMED in Europe, as well as his own particular brand of case management, especially in the elderly, he represents a large group of researchers in countries throughout the world, including Corine Latour, Frits Huyse, Fritz Stiefel, Peter De Jonge, Annette Boenink, Sylvia Ferrari, Wolfgang Soellner, Beate Wild, Aasta Heidal, Antonio Lobo, Elena Lobo, Yasuhiro Kishi, and others. Without the development of the INTERMED method for assessing multi-domain health complexity, the comprehensive assist and support program described in this book would not have been possible.

Dr. Kathol acknowledges the hard work of coauthors for *The Integrated Case Management Manual: Assisting Complex Patients Regain Physical and Mental Health*, Rebecca Perez and Janice Cohen. It was through the collaborative effort on this seminal publication that interest in and deployment of integrated case

management (ICM) principles and practices has grown to the point that it became evident that there was a need for this Physician's Guide. Numerous locations and organizations throughout the world are coming to recognize the value that a systematized and comprehensive approach to case management can bring to patients. Only by sharing information about this addition to care with the clinicians treating patients with health complexity would it be possible to maximize the benefit their patients experience.

Finally, Dr. Kathol wishes to thank Suzanne Gatteau, coauthor on his first authored book, *Healing Body and Mind*, for helping him with his writing skills. While they are far from perfect, it is only with her formative linguistic tutoring that this book could have been completed.

Dr. Hobbs-Knutson would like to thank her personal and professional mentors for supporting her development. Dr. Brad Stein has provided unlimited encouragement, meaningful feedback, and experiences that have broadened her thoughts and academic aspirations. She is grateful for the opportunities that she has been afforded as a result of the mentoring relationship. Through the Kraft Center for Community Health, Dr. Derri Shtasel also provided a unique and innovative platform for her to understand the social determinants of health on a deeper level and meaningful ways that clinicians may intervene. On a personal level, Dr. Shtasel provided wisdom and insight that only a gifted physician, academician, and mother can contribute.

Dr. Dehnel would also like to thank the staff of CMSA for their support of the pediatric complex case management development, especially Cheri Lattimer, and for the organization's abiding support of this publication. The other members of the Pediatric ICM development team—Rebecca Perez, Sherry Wilson, Teri Treiger, Deborah Gutteridge, Dr. Steven Thurber, and Dr. William Meller—provided valuable insights into the world of case management and how to translate this important activity in terms that physicians can best apply to their roles. Dr. Read Sulik provided initial insights into complex pediatric behavioral health case management that benefitted concept development. Finally, and most importantly, Peter's wife Nancy has been a constant support in many ways throughout this project.

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Part I
Overview of Case Management, Health
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Management Approach

Chapter 1

Patient Health Care Assist and Support Services, Integrated Case Management, and Complexity Assessment Grids

“Remember teamwork begins by building trust. And the only way to do that is to overcome our need for invulnerability.”

—Patrick Lencioni

The Five Dysfunctions of a Team: A Leadership Fable

Chapter Objectives

- *To review health system changes that led to the development of specialty case management.*
- *To visit the life of a complex patient and the challenge for his treating practitioners.*
- *To describe the place of case management in the patient health care assist and support services continuum.*
- *To differentiate low, medium, high, and integrated high intensity assist and support services.*
- *To introduce integrated case management-complexity assessment grid (ICM-CAG) technology.*
- *To discuss integrated complex case management’s potential contribution to the Triple Aim.*

The practice of medicine is much more complicated than in the day of the “old fashioned” house call. Providing respectful patient-centered care remains at the heart of clinician assessments and treatments. However, with the introduction of the Patient Protection and Affordable Care Act (ACA) [1], there is now also an expectation that physicians and other treating clinicians, e.g., clinical nurse specialists, physician assistants, non-physician behavioral health (BH) professionals, will optimize clinical outcomes and reduce costs in the populations of patients for whom they and their group are responsible. Thus, the face-to-face encounter is only one of several components of an increasingly complicated care delivery process. In addition to completing a patient evaluation and providing appropriate treatment, physicians are being asked to improve their communication and collaboration with others involved in the patient’s care, to use health resources efficiently, and to do so in a way that maximizes and documents long-term clinical and functional improvement for the

population as a whole, not just the individual patient [2, 3]. In the USA, often these goals are carried out through integrated clinician and health administrative networks, called Accountable Care Organizations (ACOs).

For 85 % of patients, delivering efficient, effective, and fiscally responsible care is not a problem. These individuals are mainly healthy and/or have acute or chronic illnesses that are responsive to treatment. They usually have good outcomes even when serious and costly disease is present. Appropriate clinical assessment and adherence to physician recommendations is all that is required. In this large segment of the population, perhaps the biggest challenge is to help patients stabilize and maintain their health by encouraging healthy behaviors. Prevention is a significant factor in long-term health stability, i.e., maximal control of existing conditions and prevention of new conditions or illness complications, and cost containment.

However, the 15 % of patients that use up to 80 % of health care resources [4, 5], many of whom are disabled, create the greatest challenge for physicians wishing to achieve the Triple Aim, i.e., improved care, improved outcomes, and lowered health-related cost [6]. While the Triple Aim is achieved on a patient-by-patient basis, associated population-based outcomes have gained in importance. Thus, as a greater proportion of complicated patients in this high-cost subset are efficiently and effectively treated, more value is brought to an “accountable” health system.

Most of the patients falling into this small group of high-need, high-cost patients have multimorbid medical and/or BH, which includes both mental health and substance use, disorders. These patients are confronted by a health system designed to cater to the uncomplicated 85 %. For instance, currently, most treating clinicians are paid on the basis of relative value units (RVUs), as part of fee-for-service contracts [7–10]. In this arrangement, as more patients are seen by a practitioner in a designated time period, the clinician and the clinic system are rewarded for higher productivity with increased total payment.

This simple component of the delivery system demonstrates a disconnect between the most common clinical payment procedure and the clinical needs of complicated high-cost patients. RVU-based care encourages less, not more, intensive physician involvement since a short duration of time with a patient is a marker for productivity. This has numerous consequences in both the practice of medicine and the ability of these patients to receive the care required to stabilize and maintain health.

- First, RVU-based, *time-limited* appointments compromise the ability to effectively assess and address problems in patients with complicated health needs. Case complexity billing adjustments do little to change this since often they do not alter physician compensation sufficiently to justify the significant amount of time required to understand and address patients’ complex needs.
- Second, outcomes for such patients necessarily suffer when inadequate time precludes outcome-changing assessment and intervention. Thus, numerous ineffective outpatient appointments, which do not stabilize the patient, frequently result in inappropriate emergency room use, high numbers of tests and procedures, and more frequent, often preventable, inpatient admissions and readmissions.

- Third, and logically, clinicians and clinic systems take pains to avoid inclusion of these complicated patients in their population of accountability since they exceed RVU-based time constraints. These patients are associated with lower reimbursement for services delivered, persistent illness, a greater number of clinical encounters, and excessive cost. Further, their poor outcomes reflect badly on the physicians and network providing care.
- Fourth, payment for non-physician services is often minimal, if not absent, leading to physician care that is seriously under-supported by additional clinic-based resources, such as case managers.
- Finally, complicated patients are often shuttled from clinician to clinician even in the same clinic, such as resident physician clinics and rotating practitioner public program clinics. Since no single physician gains a full appreciation of the patient's many problems, patients receive acute problem-focused rather than comprehensive care. Such care delivery is associated with occasional focal positive clinical outcomes, but total health stabilization is not part of the physician-patient equation.

So far, the discussion has described delivery of clinical health services from the practitioner and health system perspective, i.e., factors that influence the ability to make the right diagnosis and provide the right treatment. What do patients falling into the 15% with complicated health needs face when trying to get outcome-changing health care? This question can be addressed in many ways, but the most important has *nothing* to do with the physician specialty, the tests that are performed, the diagnoses that are made, or the treatments recommended. From the patient's perspective, the more pressing concerns are which providers they are allowed to see, where they can see them, and how they will pay for the care. These and other "nonclinical" barriers to improvement, such as no insurance coverage, limited transportation to appointments, poor coordination of care among their physicians, an unstable living situation, meager family support, and insufficient money to buy medications, are as, if not more, important than having a practitioner who makes a correct clinical diagnosis and prescribes an outcome changing treatment.

Physicians, nurses, and other clinicians in inpatient and outpatient settings are tasked with treating patients' illnesses, whether the health issues are medical or behavioral. If the correct diagnosis is made, then treatments most likely to reverse illness outcomes and complications can be delivered. To date, physicians and BH professionals, almost to a fault, target biomedical or psychological intervention as their primary, if not only, charge, often neglecting or overlooking nonclinical factors for which they do not see themselves as accountable. This predictably leads to poor clinical outcomes for the complex 15% with nonclinical barriers to improvement that impede the success of appropriate and effective treatment recommendations.

Patient health care assist and support personnel are a burgeoning group of individuals with sufficient education, background, and/or specific training to help achieve desired health-related outcomes. They are tasked with aiding patients/clients, and especially those with health complexity, initiate and/or follow through on health improving activities [11]. An assortment of terms is currently in use to describe this

Table 1.1 Some common terms used for patient health care assist and support personnel

-
- Lay and professional health coaches
 - Lay and professional patient navigators/assisters
 - Lay and professional care and case coordinators
 - Lay and professional care managers
 - Lay and professional case managers
 - Peer support personnel
 - Disability and workers' compensation managers
 - Lay and professional patient advocates
 - Lay and professional discharge managers/transitions of care specialists
-

broad collection of personnel, a number of which can be found in Table 1.1. In fact, the terms are commonly used interchangeably yet describe a wide range of assist and support functions that, by their nature, will have variable impact on the individuals they assist. This creates confusion about what assist and support personnel do, what credentials are required for them to do it, which type of assist and support programs require more highly trained personnel to attain health and cost objectives, and what outcomes can be expected from the services provided.

Often assist and support personnel are health professionals, such as nurses or social workers, assigned to work with patients having one or more illness and/or a complicated health and social picture that makes it difficult to achieve health stability. They can also include individuals with limited training in medical fields and/or those who only have personal experience related to certain health conditions, i.e., peer support personnel. Unlike treating practitioners, *assist and support personnel do not diagnose or treat illness*. Rather, to varying degrees, they foster healthy behaviors through patient education; advocate for and assist patients in overcoming clinical and nonclinical barriers to improvement, including adhering to their clinicians' treatment recommendations; and follow patients, measuring and documenting outcomes in collaboration with the patients' physicians to assure that goals related to health are being achieved.

Perhaps the place where assist and support personnel differ most from treating practitioners, however, is that many do not limit themselves to the patient's clinical diagnoses and treatments, i.e., the "clinical" barriers to improvement. Several, such as will be seen later in discussion of integrated complex case managers [12], also assist patients with psychosocial and health system barriers. In a true sense, assist and support personnel are accountable for helping to change components of a person's life that reduce the likelihood that he/she will get better even when effective and appropriate treatment is being given. Physicians typically do not have time to include these extended health-enhancing activities in their already busy schedules, particularly in a fee-for-service payment environment.

The purpose of this *Physician's Guide* is to assist treating clinicians and physician overseers of assistance and support programs develop sufficient understanding of the assist and support process, especially the subcategory called integrated **complex** case management (ICM, technically ICCM), so they can most effectively utilize the

skills of a new type of trained *helper* personnel, ICM managers, in achieving better clinical, functional, and cost outcomes for their patients. ICM systematically addresses multi-domain (biological, psychological, social, and health system) barriers to improvement in the most complex subset of patients and, as such, it represents a powerful aid to comprehensive care [12].

Complex Case Example: Bob

Bob will be the first in a series of complex patients whose clinical presentations will be summarized and then developed in this and following chapters. As you will see, health complexity, when conceptualized from the ICM multi-domain framework, creates challenges for treating practitioners. These challenges emanate from a variety of factors, only some of which relate to the physical or BH conditions experienced by patients. Not infrequently, however, the way that clinical services are delivered in the health system, the patient's social situation, financial issues, or even coping mechanisms (all involved in Bob's case) contribute to poor health outcomes. These nonclinical barriers to improvement are not typically considered areas of accountability by clinicians.

Bob, age 19, was one of the most expensive patients in his state public assistance program. He had been hospitalized over 20 times since age 14 for ingestions, insertions, lacerations, and injections of many articles and substances. On the latest admission, which was several months before, he had presented to the emergency room with a high fever, rigors, an unstable blood pressure, and a reddening knee. On admission, Bob said that he did not know what was causing the sudden deterioration in his health but that he felt terrible. The emergency paramedics transported him to a quaternary medical center since his current situation appeared more serious than those for which he had been treated by his rural hospital many times before.

Initially, Bob required treatment in the intensive care unit and he nearly died. He was treated for Gram-negative sepsis complicated by growth of a number of other "enteric" pathogens. In addition, he grew a strep species from his knee. It took weeks to stabilize his condition and the etiology was never uncovered. He steadfastly denied doing anything to himself and had no evidence of a compromised immune system. Whenever he was discharged to outpatient care, Bob was back in the emergency room within a day or two with a new fever or new area of induration. It was considered safer to keep him in the hospital where his behavior could be monitored.

Bob was well known to his regional medical system. Not only had he had similar "mysterious" medical presentations that led to the most recent hospitalization, he also had ingested a number of objects, such as batteries, broken glass, and pieces of ball point pins. On two occasions, it was necessary to remove items from his bladder, once a safety pin and once several pellet gun pellets.

Years previously, Bob had been seen by a psychiatrist during one of the hospitalizations for his factitious insertions (paper clip deep in urethra) and was diagnosed as having factitious and borderline personality disorders with antisocial traits.

After this initial evaluation, Bob refused to see mental health specialists. To him, his problems were “physical.” He didn’t need a “shrink.” His last behavioral health assessment was 3 years earlier. Information from it was limited. Bob had been tested for recreational substances on numerous occasions but all screens had been negative for other than known prescribed medications. His medical doctors did not consider him for psychiatric admission since he had no psychotic illness and was not suicidal. Further, he was actually a pretty likeable person according to the hospital staff that worked with him.

Little was known about Bob’s family life, schooling, work activity, or social situation. Short intake histories indicated that he lived with friends, had completed high school, and was not working. Outpatient follow-up for numerous medical problems were addressed by a local community health center. There was no steady primary care physician since Bob tended to be non-adherent, used the emergency room a lot, and kept getting sick and/or having complications. No one wanted him on his or her panel of patients. At this point, Bob’s primary residence was the hospital, where he received magazine subscriptions in his daily mail. He had few visitors, none of whom were family.

Bob had been receiving treatment for many persistent and recurring problems from medical practitioners for the previous 5 years. Essentially, his treatment targeted acute exacerbations of documentable medical conditions. However, his presentations suggested that Bob had BH comorbidity that was contributing to his recurrent hospitalizations, yet Bob refused evaluation, let alone treatment, from BH professionals. Without significant change in the approach to Bob’s care, it was likely that Bob would remain among the highest users of medical services in his state for years to come if he didn’t die first.

The remainder of this chapter will describe the general practice of patient health care assistance and support and close with an introduction to integrated complex case management. Since treating clinicians are already hard pressed to complete their days in time for dinner, they should reflect on Bob as they read. How and which type of assistance and support might have helped Bob achieve a better long-term outcome than he had experienced for the last 5 years?

Patient Health Care Assistance and Support Terminology

Patient health care assistance and support is defined above and is often associated with use of a wide variety of interchangeable terms in the health care industry, some of which are listed in Table 1.1. For purposes of this *Physician’s Guide*, we have chosen to use “patient health care assistance and support” as an overarching description for general helper activities on behalf of individuals with health-related needs and “case management” to designate the subset of more intensive helper activities that is best provided by licensed or case management certified, trained health professionals.

Constituencies within the patient assist and support community foster use of the term they favor. None, to date, has reached predominance, such that it has greater uniformity of meaning or industry support for its use. Additionally, new terms with specific presumed meaning continue to surface, such as “professional health coaching,” though the description of these professionals’ activities are congruent with those described by numerous other industry patient assist and support terms in common use.

Terms are chosen for a variety of reasons. For instance, “patient navigation” and “care coordination” are terms preferred to “care management” or “case management” by some since no patient wants to be “managed.” “Management,” on the other hand, is perhaps a better descriptor of personnel activity since assistance and support includes more than just finding the right practitioner or service location, which is implied by the term “navigation,” or the coordination of care by treating practitioners, as is implied by “care coordination.” Further, some prefer “care” to “case” management since it is a term that implies patient centeredness. Even “care management” does not capture the breadth of activities by assistance and support personnel, however, since many assist and support personnel address nonclinical, i.e., non-care-related, barriers to improvement as a part of their accountability.

Up to this point, we have been careful to use “personnel” rather than “professionals” to describe those who provide assistance and support. This is because there is as much confusion about the level of education, background, and training as there is about the terms used to describe assistance and support. Non-health professionals commonly perform such tasks as “lay health coaching” or “wellness counseling.” These are characterized by performance of activities that encourage healthy behaviors, whether by distribution of educational materials on diet and exercise, participation in health fairs, or encouraging smoking cessation in largely healthy populations. This type of assistance and support does not require professional expertise to effectively complete tasks associated with it.

Other forms of patient assistance and support capitalize on the skills of licensed or case management certified health professionals who proactively assess and then assist those with health conditions, i.e., help “patients” with illnesses, in identifying and addressing areas in their lives that lead to illness development and/or persistence. Patient assistance and support in this context is intended to be an active force that fosters progress toward improved health related to existing conditions in those exposed to it. Helping patients navigate a complicated health system and facilitating coordination of care are clearly a part of this charge. However, these activities need to be supplemented by educated and experienced professionals who use their understanding of illness and the health system to support patients with treatment-resistant health problems. This need for educated and experienced health professionals is especially important for medium, high, and integrated high intensity assistance and support activities (covered below).

In the *Physician’s Guide*, the term “case management” is used to describe the professional activities, including patient education, health facilitation, care coordination, patient navigation, promotion of “treat to target,” and client/patient advocacy with the goals of reversing barriers to health improvement and stabilizing health. The professionals who provide medium- to integrated high intensity

Table 1.2 Case management Standards of Practice 2010

-
- Case managers with active licensure and up to date competence in their specialty area of practice should be able to perform the following case management support operations:
 - Patient/Client-Centered—collaborative
 - System-Centered—access and care coordination
 - Illness-Centered—chronic and multimorbid
 - Outcome-Centered—clinical, functional, satisfaction, quality of life, financial
-

Data from Case Management Society of America. *CMSA Standards of Practice for Case Management*. Little Rock: Case Management Society of America; 2010

Table 1.3 Components of the case management process

-
- Patient identification
 - Case management assessment
 - Care plan development
 - Implementation of care plan activities
 - Ongoing evaluation of goals and outcomes with escalation of care
 - Patient graduation
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Data from Powell SK, Tahan HA. *CMSA Core Curriculum for Case Management*, Philadelphia, Lippincott Williams & Wilkins, 2007

assistance and support are referred to as “case managers.” These individuals are trained in the case management Standards of Practice (Table 1.2) and are able to perform core components of the case management process (Table 1.3) either independently or under the supervision of more experienced case managers. Most “lay” assist and support personnel do not have the level of health care sophistication needed to achieve meaningful outcomes for those with complicated and interacting health issues. Their backgrounds limit their ability to be trained to conduct comprehensive case management assessments, to build care plans from them, or to independently pursue corrective action plans.

Utilization Management

Patient health care assistance and support differs from “utilization management” (UM) in that it *helps individuals* with health-related needs, irrespective of benefits or coverage. UM, on the other hand, assesses whether an individual has insurance coverage for a medical or psychological service (including individualized patient assistance and support) and/or whether the individual has a medical or psychological condition, which would benefit from implementation of a clinical service if coverage exists, i.e., determination of medical necessity. UM is more correctly considered “benefit” management and not “assistance and support.”

While UM decisions are often necessary in patients receiving assistance and support services, it is not an endorsed activity for assistance and support personnel. In many situations, combining the two roles creates conflicts between the helper activity of the assist and support personnel to the patient and the need to adjudicate a service, i.e., denial of a medical or psychological service for an individual without coverage when the service is needed for health improvement. This *Physician's Guide* will not discuss UM further, other than to recommend that organizational personnel independent of, but available to, assistance and support personnel perform the majority, if not all, benefit (utilization) management services.

A word of caution, however, is necessary since many health plans, care delivery systems, and management vendors also use the terms in Table 1.1 to describe personnel who are actually doing UM. For this reason, in today's health care vernacular, one cannot rely on the term used to describe assist and support personnel in health care settings. Rather, it is necessary to inquire about the specific role that these personnel play in their jobs, which will be discussed later in the chapter. A key factor that differentiates "assist and support personnel" from "utilization managers" is that the latter rarely work directly with patients but rather interface with hospitals and clinicians in the background to prevent inappropriate delivery of services that are not covered or are adjudicated as unnecessary. If direct patient contact occurs between the utilization manager and the patient, it is usually to report approval or denial of services.

Incidentally, competent utilization managers do not easily transition to assist and support personnel, and vice versa. The activities by these two specialists come from opposing conceptual frameworks and do not mix well together, i.e., utilization managers *approve or deny* care/services while assist and support personnel *help* patients overcome barriers to improvement. Utilization managers are adjudicators and assist and support personnel are problem solvers.

Assistance and Support Program Intensity

There are many ways in which health-related assistance and support can be divided. Some dimensions could include the population served; the health condition targeted; the desired outcome; the location of the client/patient; the assistance and support personnel caseload; the location of the service delivered; results accountability; the method of delivery, e.g., face-to-face versus telephonic; the education/background and training needs of the personnel providing assistance and support; and the duration of the assistance and support activity. The most helpful place to start, however, is subdividing assistance and support based on its level of intensity (Table 1.4).

Assistance and support intensity consolidates:

1. The complexity of the health issues for which help is being sought.
2. The level of expertise and proactive involvement needed by the assistance and support personnel.
3. The characteristics of the assistance and support process required for goals to be met.
4. Desired clinical, functional, cost, and other anticipated outcomes.

Table 1.4 Intensity-based health-related patient assistance and support

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- Low assistance and support intensity (preventive health and health support)
 - Clients/patients—generally no/low but variable complexity and cost
 - Assistance and support personnel—little health-related education or experience needed; training required
 - Helper function—short-term, high caseloads, process-oriented goals
 - Medium assistance and support intensity (general or targeted case management)
 - Patients with health conditions—medium but variable complexity and moderate cost
 - Case managers—health-related professionals or health care experience; training required
 - Management—short- to medium-term, medium to high caseloads, mix of process-oriented and measured-health outcomes
 - High assistance and support intensity (complex case management)
 - Complex patients—high health complexity and cost (top 10–15 %)
 - Case managers—medical or BH nurse, social worker (case management certification desirable), or health professional with case management certification, training required
 - Management—medium- to long-term, medium to low caseloads, measured-health outcomes
 - Integrated high assistance and support intensity (integrated case management)
 - Complex comorbid patients—biopsychosocial and health system barriers (top 2–8 %)
 - Case managers—ICM trained and experienced health professionals; cross-disciplinary service
 - Management—medium to long-term, low caseloads, measured-health outcomes
-

An intensity stratification helps treating clinicians conceptualize assistance and support activity as it moves from a clinical service enhancement, i.e., a better patient experience, to a contributor to the Triple Aim, i.e., also improved health and cost savings.

Low intensity assistance and support is typified by the delivery of help to clients or patients for hours to weeks by personnel that do not require health-related expertise in order to successfully complete the *process* of outcome-based assist and support activities. In *medium intensity assistance and support*, also called “case management,” case managers require health-related education and experience in the health care industry, such as licensed health care professionals or those with certifications that allow independent full patient assessments. Without this background, they will possess limited ability to work with patients for which proactive, constructive, health-related assistance is essential if patients are to consistently show improvement in their health conditions. With medium intensity case management, helper activities, dispensed over days to months, are consistent with application of the case management Standards of Practice [11] and target mixed *process-* and *measured-health* outcomes.

High intensity assistance and support, also called complex case management, uniformly targets more complicated and high-cost patients who are found in any given population. *Complex case managers* come from a pool of nurses, social workers, or other licensed health care professionals able to implement the case management Standards of Practice [11] in patients with complex health conditions. Non-health care or peer support personnel generally cannot effectively deliver this

level of case management but can work in collaboration with complex case managers to expand the percent of the population assisted. Complex case managers complete comprehensive assessments, develop care plans based on assessments, and provide assistance for months to years while attempting to achieve measured health outcomes that contribute to the Triple Aim [6].

Integrated high intensity assistance and support, also called integrated (complex) case management, is a form of complex case management in which experienced nurses, social workers, and other licensed or certified professionals with either medical or BH backgrounds receive specialized training in the delivery of multi-domain, i.e., biopsychosocial and health system, and cross-disciplinary, i.e., medical and BH, case management assessment and assistance. This form of management is designed to maximize value for the most complex medical or BH patients, especially those with concurrent medical *and* BH conditions. It can be used equally well, however, in patients with less health complexity and in those with medical only, BH only, or combined medical and BH disease.

Examples of common forms of assistance and support activities described in the published literature that are generally categorized as low, medium, high, or integrated high intensity can be found in Table 1.5. For each of these categories, however, there is considerable confusion about the manager expertise that is needed, the optimal duration of intervention, the core activities provided, and what constitutes value-based outcomes. In fact, many assistance and support personnel reviewing Table 1.5 may take exception to where their particular named brand of assistance and support has been placed in the list.

For instance, disease management, considered medium intensity assistance and support, describes the process by which case managers assist patients with a certain medical condition, such as diabetes or depression. While these managers work with

Table 1.5 Examples of intensity-based health-related assistance and support programs

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- Variable
 - Health plan management, adult and pediatric inpatient and outpatient management, accountable care organization (ACO) management, government and military program management
 - Low intensity assistance and support programs
 - Health care coaching, also called wellness counseling; employee assistance counseling; discharge management; peer support; lay patient navigation; lay care coordination; lay in-home caregiving
 - Medium intensity assistance and support programs
 - General case management, medium tier county/state program management, high need disability and workers' compensation management, disease management, elderly and disabled nursing home management, palliative care management
 - High intensity assistance and support programs
 - Comprehensive medical case management, Assertive Community Treatment (ACT) team management, intensive case management
 - Integrated high intensity assistance and support programs
 - Adult and pediatric integrated case management
-

patients having a specific disorder, the actual assistance by the manager for the patient could range from short-term isolated tasks, e.g., providing educational materials, approving services, or medical devices, assuring discharge continuity, or finding a specialist (all low intensity assistance and support or utilization management activities); to medium-term targeted assistance, e.g., coordinating communication among clinicians and clinic systems, facilitating rapid recovery and return to work (consistent with medium intensity disability or workers' compensation management); to medium- to long-term assistance in overcoming barriers to improvement, e.g., helping to find affordable insurance products, resolving trust issues with physicians, measuring outcomes, and helping to pursue next steps in care (consistent with high intensity case management).

In order to provide a framework for treating clinicians in this chapter, we have consolidated named categories of assistance and support programs (examples seen in Table 1.5) into low, medium, high, and integrated high intensity programs and defined general characteristics of each (Table 1.6). While it takes time to go through Table 1.6, it is well worth doing. Each level is delineated by the population served; the triage process; assistance personnel backgrounds, training, and activities; and caseload expectation and intensity of contact. From these, it is possible to project program outcome accountability and expectations. The Table allows readers of the *Physician's Guide* to translate where their own local program or one described in the literature fits into the intensity grid, regardless of the name applied to the program, and to anticipate, based on its intensity characteristics the expected clinical and cost outcomes.

Assistance and Support Personnel Competency Levels

Column four in Table 1.6 describes educational, experience, and training characteristics of personnel most likely to be able to perform assist and support activities at each level of program intensity. The Assist and Support Personnel Competency Map (Table 1.7) further elucidates the background and skills needed to perform at various levels of program intensity. While senior case management specialists (Level 4C) who are qualified to perform higher intensity activities can equally well perform low-level intensity activities (and often do, including utilization management), the reverse is not true. Health support personnel (Level 1C), who are not health professionals and often have minimal understanding of illness and the health system, do not have the backgrounds needed to perform more than the most basic assist and support tasks without supervision. On the other hand, those at Level 1C who are successfully trained in the case management assistant role can be of great value when working on a team also composed of those with Level 2C through 4C competencies. Under supervision, Level 1C case management assistants can expand the reach of case management programs of all intensity levels while conserving resources.

Table 1.6 Intensity-based assistance and support general program characteristics

Assistance and support intensity level	Population served	Patient triggering	Personnel education, experience, and training	Personnel activities	Typical caseload; annual cases	Assistance duration; intensity of contact	Content; outcome accountability	Cost outcome expectation
<i>Integrated high intensity [Integrated [Complex] Case Management [ICM]]</i>	Chronic medical <i>and/or</i> behavioral illness out of control; very high cost	Systematic identification of high risk, high cost chronic medical <i>and/or</i> behavioral adults and children	Experienced licensed health professional able to implement ICM practices (usually case management certified); training in ICM	Biopsychosocial and health system assessment, care plan development and implementation, records measured health outcomes, graduation	20–50; one to two hundred	Months to years; heavy to medium interaction across medical <i>and</i> behavioral service settings	Biopsychosocial and health system; measured total health and cost improvement	Direct and indirect; predictable ROI is medium to high and measured in months to years
<i>High intensity (Complex Case Management)</i>	Chronic medical <i>or</i> behavioral illness out of control; high cost	Systematic identification of high risk, high cost chronic medical <i>or</i> behavioral patients	Experienced licensed health professional able to implement case management Standards of Practice (usually case management certified); training in local work processes	Targeted medical <i>or</i> behavioral comprehensive assessment, care plan development and implementation, variable outcome measurement, graduation	Less than 75; hundreds	Months to years; heavy to medium interaction across medical <i>or</i> behavioral service settings	Medical <i>or</i> behavioral; case management process completion (occasional measured-health improvement)	Direct and indirect; likely ROI is medium and measured in months to years
<i>Medium intensity (Case Management)</i>	At-risk patients with illnesses; low to medium cost	Sometimes triage of population for chronic illness <i>or</i> health risk	Licensed health professional with understanding of case management Standards of Practice; training in local work processes	Process algorithm completion with use of medical knowledge and experience, process outcomes measured	Less than 200; hundreds to a thousand	Weeks to months; medium to light interaction across service setting	Medical <i>or</i> behavioral; process algorithm completion (occasional measured-health improvement)	Direct and/or indirect; ROI, if present, is low and measured years later
<i>Low intensity</i>	Generally healthy but “at risk;” low cost	Defined population without triage	High school education or above and no experience necessary; algorithm training required for effectiveness	Process algorithm completion	Variable; hundreds to thousands	Hours to weeks; light interaction in specified service location	Medical <i>or</i> behavioral; process algorithm completion	Variable but, if present, ROI is low and generally measured years to decades later