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

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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 **IC**CM), 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

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

- 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

- 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
Integrated high intensity (Integrated [Complex] Case Management [ICM])	Chronic medical *and/or* behavioral illness out of control; very high cost	Systematic identification of high risk, high cost chronic medical *and/or* 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 *and* behavioral service settings	Biopsychosocial and health system; measured total health and cost improvement	Direct and indirect; predicable ROI is medium to high and measured in months to years
High intensity (Complex Case Management)	Chronic medical *or* behavioral illness out of control; high cost	Systematic identification of high risk, high cost chronic medical *or* 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 *or* 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 *or* behavioral service settings	Medical *or* behavioral; case management process completion (occasional measured-health improvement)	Direct and indirect; likely ROI is medium and measured in months to years
Medium intensity (Case Management)	At-risk patients with illnesses; low to medium cost	Sometimes triage of population for chronic illness or 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 *or* behavioral; process algorithm completion (occasional measured-health improvement)	Direct and/or indirect; ROI, if present, is low and measured years later
Low intensity	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 *or* behavioral; process algorithm completion	Variable but, if present, ROI is low and generally measured years to decades later

Table 1.7 Assist and support personnel competency map

Assistance and support competency level	Education	Experience	Training	Assist and support activities	Role examples
Level 4C: case management senior (specialist clinician)	Licensed health care professional; case management certification	One or more years working at Level 3C; demonstrated leadership skills	Staff/program supervision; skills in educating staff about case management; integrated case management	Independent application of longitudinal complex case management; team leader; trains Level 2C and 3C managers	Integrated case manager; care coordination supervisor of Level 1C to 3C managers; management educator
Level 3C: case management mid career (mature clinician)	Licensed health care professional; often case management certification	One or more years working at Level 2C; management of complex patients	Training in case management allowing judgments and decisions on care plan direction and execution; staff supervision	Able to apply the case management Standards of Practice (Table 1.3) in complex patients; supervises Level 1C and 2C managers	Complex case manager; case management supervisor
Level 2C: case management entry (novice clinician)	Licensed health care professional; training in core case management work processes	Initial use of core case management work processes (see Table 1.2)	Training in protocols, procedures, or workflows associated with assist activities and application of case management principles	Can apply care plan protocols, procedures, and workflows under supervision; works with Level 1C personnel	Clinician-based care coordination; complicated care transitions; workers' compensation
Level 1C: health support personnel	Secondary school or above	Appreciation of the need for health and healthy behaviors	Basic training in protocols, procedures, or workflows associated with assist activities	Clinical, technical, or administrative duties using protocols, procedures, or workflows with patients/clients	*Unsupervised*: health coach; family caregiving; lay navigation *Supervised*: care coordination; peer support; case manager assistant

Table 1.8 Descriptions of several types of low intensity assist and support programs

- *Health care coaching, wellness counseling*—assist clients understand (and implement) habits of healthy behavior who are at risk for development of health conditions or complications from existing conditions (Level 1C)
- *Employee assistance programs*—help employees address workplace, family, financial, and health issues to maximize health, well-being, and workplace productivity (supervised Level 1C and 2C)
- *Discharge management (transitions of care)*—confirm medication reconciliation, timely outpatient clinician appointments, and filled prescriptions for recently discharged hospital inpatients (supervised Level 1C and 2C)
- *Lay in-home caregiving*—assist patients with home health needs as an alternative to a skilled nursing facility (Level 1C or 2C depending on need)
- *Lay navigation*—assist a target population find and access needed services (supervised Level 1C and 2C)
- *Lay care coordination*—assist a target population coordinate provider and system services (supervised Level 1C and 2C)

Levels 2C through 4C are composed of health professionals with increasing amounts of education, experience, and training. Those with higher competency play increasingly important roles in programs of higher intensity. Not listed in Table 1.7 are Levels 5C (those with the skills needed to assume program managerial positions) and Level 6C (those with educational, experiential, and leadership skills which allow them to assume executive positions in the health care industry).

Low Intensity Assistance and Support Programs

Level 1C and 2C personnel can provide assist and support programs that fall into the low intensity category (Table 1.8). These programs require practitioners with little background or experience in the health care field but with a general appreciation for the importance of health maintenance and behavior. Level 1C personnel can have as little as a high school education and no previous health-related training or employment experience. For instance, peer support personnel include those who have or have previously experienced a chronic health condition, such as substance dependence, human immunodeficiency virus (HIV) infection, kidney disease, or asthma. Level 1C personnel and 2C professionals always require training in the type of assist and support activities they will be performing, and they often need Level 3C or 4C case manager supervision to understand how to contribute to improved health and function and to cost reduction. Only then can they effectively work toward the measureable goals of the assist and support activity.

Level 1C personnel activities often include work with populations of individuals, some with an underlying illness but some without. For instance, health care coaches target at risk subsets of otherwise healthy populations (*clients, not patients*) to help them adopt a healthy lifestyle. This is a common benefit provided by health conscious employers. In this capacity, it is often possible to train these individuals to perform unsupervised assistance activities.

Of course, some Level 1C personnel and Level 2C professionals routinely work with those having illness, such as in discharge management programs that use work process algorithms. These programs help patients transition from inpatient to outpatient settings by assuring that patients understand their discharge medications, fill their prescriptions, and see their outpatient care provider who has received information about their hospitalization. By doing so, these assist and support personnel promote and speed return to health, mitigate adverse transition events, and decrease the potential for hospital readmission. Supervision by Level 3C or 4C professionals is generally advisable since an understanding of medications is needed and unforeseen circumstances often arise. Primarily, however, assist and support personnel need only to know the mechanics of best practices in this area of targeted assistance [13].

Medium Intensity Assist and Support (Case Management) Programs

Medium intensity assist and support (Table 1.9), hereafter called general or targeted "case management," programs, require assistance and support by "case managers," i.e., those with a greater appreciation of common illnesses and medications and the system in which medical and/or behavioral treatment is provided. These managers can perform at Levels 2C through 4C (Table 1.7). Base knowledge for case managers comes through education in a health profession and health-related employment and/or through a certification program that includes independent assessments. In all cases, it is accompanied by specialized training in the principles (Table 1.2) and practice (Table 1.3) of case management. In today's world, case management is generally an added qualification in nursing and social work. Other licensed health professionals, however, can pursue additional training and certification in it as well.

Assisted *patients* in case management programs typically have one or more chronic medical or BH condition and have as much difficulty accessing the right care as they do in getting the right diagnosis and treatment. Thus, only case managers

Table 1.9 Descriptions of several types of medium intensity assist and support programs

- *Medical case management*—assess and assist patients with low to medium levels of medical health need connect to clinicians and receive outcome changing services in the care delivery system and from the community (Level 2C, 3C, and 4C with Level 1C assistants)
- *Disability management; workers' compensation*—insure that employees with work-impacting injuries or illnesses receive the health care support they need while on benefits (Level 2C, 3C, and 4C with Level 1C assistants)
- *Behavioral case management*—assess and assist patients with low to medium levels of behavioral health need connect to clinicians and receive outcome changing services in the care delivery system and from the community (Level 2C, 3C, and 4C with Level 1C assistants)
- *Disease management*—assist patients in receiving the best care for specific illnesses, e.g., diabetes, depression, asthma (Level 2C, 3C, and 4C with Level 1C assistants)

with a basic understanding of common medical or behavioral conditions and the challenges that patients face in accessing and receiving needed clinical attention, i.e., competency Level 2C and above, are likely to achieve health and cost outcomes in medium intensity programs. This is one feature that differentiates the capabilities of case managers from those able to function in a number of low intensity assist and support programs. It also distinguishes them from concerned relatives or friends who attempt to provide a similar type of assistance but without the benefit of what can best be described as "medical savvy."

Medical savvy is a tangible, intangible that, for example, allows medium intensity case managers to understand:

- When patients are not adhering because they don't understand the recommended treatment.
- When the emergency room could be replaced as the primary source of care due to the presence of local primary care physicians with urgent care clinic capabilities and the potential for care continuity.
- When noncommunication among the patient's practitioners is leading to conflicting messages concerning the patient's care and ultimately clinical nonresponse.
- When finding the patient housing may be a more important first step in controlling illness than helping the patient fill a prescription.

Medical savvy does not mean that the case manager, whether at Level 2C, 3C, or 4C, has an in-depth understanding of each illness or its treatment. Nor does it mean that the case manager has an understanding about all the community resources that could be used to augment outcomes for a given patient. It does, however, mean that the case manager has enough understanding of illness and the delivery system to know how to creatively find and use the answers when barriers to improvement are occurring. The case manager employs her or his informed understanding and motivational interviewing skills to engage patients in change behaviors that promote progression to better health.

As illustrated in Table 1.9, there are many general and targeted case management subgroups. While the case managers themselves have educational backgrounds and/or experiences allowing them to augment patient outcomes, they also require training, regardless of their level of competency, in the specific subtype of management in which they are involved. For instance, middle tier state or county program managers, who work with patients with medium to highly complicated conditions in public health settings, would target skill development in understanding access and treatment locations that accept Medicare, Medicaid, and public assistance insurance; publically funded assistance programs; community resources; wrap-around services; and others supporting those in state and county programs. Ideally, these case managers would assess and then assist patients in getting the care that they need. Not only would they connect patients to needed clinicians, they would also know how to help patients find treatment resources, uncover monetary support programs (such as for drugs at reduced costs), and promote follow through on their treating clinician's recommendations.

On the other hand, high need workers' compensation managers, another type of targeted medium intensity case manager, focus on services for work-related injuries

in employees. The majority with work-related injuries do not require case management assist services. Those with complicated recoveries, e.g., those who are not improving at an anticipated rate or for whom there is concern about fraud, however, may need a case manager to help ensure that health care support and treatment leads efficiently to return to work. Thus, high need workers' compensation managers must understand not only basics of common job-related injuries and the health system, but also details related to payment for workers' compensation injuries, the availability of employee assistance benefits, workers' compensation state and federal regulatory rules, the art of attending workers' compensation clinic visits, and back-to-work options for employees reentering the workforce. This all requires customized training tailored to the specific role of the case manager.

There are many other locations and populations in which case management is delivered, such as in nursing homes; in primary care, specialty medicine, and specialty BH clinics; in specialty medical and behavioral inpatient units; on military bases; and at veteran hospitals. While this list is not exhaustive, it illustrates locations and populations that benefit from managers who are certified in case management or are licensed in health-related professions, e.g., occupational therapy, physical therapy, psychology, social service, pharmacy, and nursing, and have training customized to the population they serve. Importantly, case managers know how to productively use their core understanding of health and care, the medical literature, medical colleagues, community resources, and their organizational support system to assist patients in moving steadily and predictably toward improved health and function. These are core components of case management education during the credentialing process.

While case managers are often driven by process outcomes, in the future, they will be increasingly expected to utilize their medical/clinical backgrounds and expertise to achieve actual clinical and functional (*measured health*) outcomes. For instance, disease managers will be graded on their ability to help stabilize chronic medical conditions and decrease illness complications. Workers' compensation managers will be considered successful when they speed employee recovery and return to work. The number of disease manager-based calls or workers' compensation assessments, both process measures, may be steps to accomplish measured health outcomes but, in themselves, do not provide evidence that health outcomes improve. Thus, measurement of health and cost outcomes will increasingly be incorporated into productivity reports to ensure that actual value is brought to patients, to clinicians, and to the health system.

High Intensity Assist and Support (Complex Case Management) Programs

High intensity assistance and support, hereafter-called *complex case management*, is differentiated from lower intensity programs in that it specifically targets patients with complicated, high cost, and multimorbid health problems (Table 1.10), i.e., those with high health complexity (more on this in Chapter 2). Low- and

Table 1.10 Description of several types of complex case management programs

- *Comprehensive case management*—assistance to patients with one or more catastrophic medical conditions (high biological complexity) in the coordination of medical services and rehabilitation to stabilize health and maximize function (medical Level 3C and 4C with 1C and 2C assistants)
- *Assertive Community Treatment (ACT) team and intensive case management*—assistance to patients with chronic serious mental health and substance use disorders (medium to high psychological complexity) control illness and improve function in the community setting (BH Level 3C and 4C with 1C and 2C assistants)
- *Traditional integrated case management*—longitudinal assistance to complex medical or BH patients in reversal of primary disciplinary barriers to improvement so that there is primary discipline illness stabilization and improved function coupled with referral to cross-disciplinary case manager assistance for assessment and assistance with comorbid condition (medical or BH Level 3C and 4C with 1C and 2C assistants with referral to cross-disciplinary assist and support personnel with unknown qualifications and work processes)

medium-intensity assist and support programs may occasionally have complex patients, but mainly service the needs of patients showing less acuity and complicating factors, having fewer comorbidities, or those who are at risk for but have not developed health complexity. For example, discharge management, a low-intensity program, is characterized by algorithmic assistance to *all* patients discharged from the hospital. While all have had a condition for which inpatient services were required, it does not necessarily mean that they are complicated at discharge. For instance, most patients who have had hip surgery experience uncomplicated convalescence and recovery. They, like many discharged patients, fall into the noncomplex category yet all are included in most discharge management programs. Only a small subset of patients has complicated post-hospitalization needs, and even for these patients, the focus is on the process of securing ongoing care and treatment during the transition after hospitalization. While these processes may support long-term health, the measured outcome usually is not clinical and functional improvement per se. Discharge management cannot be said to target complex patients, but rather post-acute patients.

In contrast, correctly configured, *complex* case management that targets patients at discharge would task case managers with the responsibility of improving outcomes through assistance and support *only* for complicated, high-cost discharged patients. These patients have many barriers to improvement and are at high risk for negative post-discharge outcomes. Furthermore, the work processes that complex case managers would use would likely be much more extensive than those associated with mere transition from one to another level of care. To varying degrees, they would assist these complex patients control the ravages of their underlying illness as well as the effects that uncontrolled and persistent illness has had on their personal, social, and economic lives, such as job loss, limited or no insurance, an unstable living situation, or poor social support.

Logically, since patients in complex case management programs have more intense manifestations of illness and illness consequences, complex case managers

would be expected to have greater success if they were more highly educated in a clinical discipline, had experience with sick patients in a complicated health system, and were more versed in the implementation of the case management Standards of Practice specifically in patients with health complexity. Case managers falling into competency Levels 3C and 4C fit this bill. Complex case managers would be called upon to utilize their understanding of illness and the health system to solve problems that less qualified assist and support personnel cannot.

While Level 3C and 4C case managers are at the top of the discipline-specific case management pyramid, they are limited in number and an extremely valuable resource. Many programs have found that the work of complex case managers can be expanded if less well-trained/qualified personnel with an understanding of complex case management assist and support work processes, such as Level 2C case managers or Level 1C personnel, act as case manager assistants. While they cannot complete comprehensive assessments or develop detailed plans of care performed by complex case managers, they can facilitate completion of clinical, technical, and administrative action items needed to achieve complex patient goals. This is an important consideration when deploying complex case management programs and is more fully described in Chapter 8.

Integrated Medical and BH High Intensity Assistance and Support Programs (Integrated Adult and Pediatric [Complex] Case Management)

Ostensibly, traditional case management does not make a distinction between the assist activities for medical and BH patients; however, a review of published literature and case management training programs shows that most case management programs focus on either patients with medical or BH conditions [12]. For instance, literature on complex case managers suggests that they either address the medical needs of patients, e.g., comprehensive medical case management, or the BH needs of patients, e.g., Assertive Community Treatment and intensive case management, but not both. When concurrent cross-disciplinary conditions are present in either setting, which is the case for 60–80 % of those with complex health situations, and there is a desire to address cross-disciplinary needs, then patients in traditional complex case management settings are referred to cross-disciplinary case management personnel as the primary and often the only assistance activity (Table 1.10). This is what we term "traditional integrated case management."

Communication between medical and BH case managers for such patients is typically sparse if it occurs at all. Patients are referred with the presumption that cross-disciplinary assistance will be given that has little to do with case management assistance and support for the primary discipline's needs. Data on patients

with concurrent medical and BH issues belies this presumption as medical and BH conditions are often intertwined and act synergistically to promote poor health outcomes (covered in greater detail in Chapter 2). Thus, there is a need for an integrated approach to medical and BH case management in the majority of patients with health complexity.

It is for comorbid complex patients that adult and pediatric ICM was developed. ICM has all of the requirements that complex case management does, i.e., delivered by mature licensed or case management certified health professionals, such as nurses and social workers, with training in the case management Standards of Practice. Case management services are provided to high-need, high-cost patients during a longitudinal course of assistance. Like many complex traditional case management programs, ICM targets measured health outcomes as a primary goal and involves intensive work with patients until health has stabilized or maximum benefit has been achieved.

ICM, however, differs from complex case management in several important ways (Table 1.11). First, it is built on a complexity, rather than a disease, platform. This allows ICM managers to assist in the care of patients regardless of their underlying illness. Second, it considers the relationship between the patient and the case manager as a primary factor in achieving the changes desired to stabilize health. Therefore, a focus on relationship-building and trust between the ICM manager and the patient is woven throughout the care process, beginning with the comprehensive assessment, which uses a semi-scripted dialogue between the patient and the ICM manager. It is designed to support relationship development while data gathering occurs. Third, ICM targets clinical and nonclinical barriers to improvement in the

Table 1.11 Traditional versus integrated case management

Traditional	Integrated
• Illness-focused	• Complexity-focused
• Problem-based	• Relationship-based
• Diverse triggering methods	• Complexity-based triggering
• Case managers trained in general medical or BH case management	• Case managers trained in bio-psycho-social and health system data entry
• Pediatric case management based on child/youth manager experience	• Systematic pediatric complexity-based case management capability
• Mental health management support requires manager handoffs	• Cross-disciplinary management support without manager handoffs
• Illness targeted patient assessments, goals, and actions	• Goals and actions linked to multi-domain assessments
• Process orientation and measurement—cases touched, calls made	• Health outcome orientation and measurement—clinical, functional, fiscal, satisfaction, quality of life
• Manager caseload dictated by case triggers and process targets	• Manager caseload dictated by level of complexity and outcome expectation

Table 1.12 Integrated case management-complexity assessment grid (ICM-CAG scored example)

Baseline	HEALTH RISKS AND HEALTH NEEDS					
Lucinda	HISTORICAL		CURRENT STATE		VULNERABILITY	
Total Score = 38	Complexity Item	Score	Complexity Item	Score	Complexity Item	Score
Biological Domain	Chronicity HB1	3	Symptom Severity/Impairment CB1	3	Complications and Life Threat VB	3
	Diagnostic Dilemma HB2	0	Diagnostic/Therapeutic Challenge CB2	3		
Psychological Domain	Barriers to Coping HP1	1	Treatment Adherence CP1	2	Mental Health Threat VP	2
	Mental Health History HP2	2	Mental Health Symptoms CP2	2		
Social Domain	Job and Leisure HS1	1	Residential Stability CS1	0	Social Vulnerability VS	1
	Relationships HS2	0	Social Support CS2	1		
Health System Domain	Access to Care HHS1	2	Getting Needed Services CHS1	3	Health System Impediments VHS	3
	Treatment Experience HHS2	3	Coordination of Care CHS2	3		

assessment and care assistance process. Using a multi-domain, i.e., biopsychosocial and health system, complexity assessment approach, information about clinical and nonclinical factors impeding return to health is systematically gathered and becomes a part of the assistance process. In many situations, nonclinical factor correction takes precedence over clinical factors.

Fourth, ICM managers address both medical and BH needs without handing the patient to another case management professional. Since case managers do not treat patients but merely assist them in getting the treatment they need, patients can have primary medical conditions alone, primary BH conditions alone, or co-occurring medical and BH disorders and benefit from ICM. ICM training is needed to help managers learn to address both types of conditions but does not require a background in either medical or BH service delivery per se.

Fifth, measured health outcomes are core to the ICM process. Thus, ICM managers collaborate directly with their patients to create a prioritized plan of care that contains patient-centered goals and actions. They then work together to achieve directly measured management goals as well as global clinical, functional, quality of life, satisfaction, and cost outcomes. As barriers to improvement are reversed and health is stabilized, then "graduation" from ICM becomes possible.

Finally, ICM has built-in features that many other forms of case management do not have. It uses a color-coded complexity grid to simplify identification of prioritized care plan items (Table 1.12). It includes both adult and pediatric ICM assessment and intervention capabilities. It has the potential to be used as a caseload estimator since the complexity grid provides a numeric complexity score for each patient. It uses ICM tools specifically designed to document and follow complexity issues over time. Lastly, the ICM tools incorporate a method for determining when it is appropriate to start planning for case closure. All of these features will be described in detail in Chapter 6.

Integrated Complex Case Management's Potential Contribution to the Triple Aim

Treating clinicians should now have a basic understanding of the distinctions among low intensity assistance and support, case management, complex case management, and integrated complex case management. During the remainder of the *Physician's Guide*, the authors will specifically target a full appreciation for the value that integrated complex case management brings to patients, their providers, and the health system. The intent of this focused attention is not to suggest that lower intensity forms of case management, including low intensity assistance and support, are not important and cannot potentially bring value to patients and the health system. A number have been demonstrated to do so. Rather, we have chosen to prepare the *Physician's Guide* so that treating practitioners understand how to work with an increasingly important contributor to measured health outcomes and cost reduction, i.e., ICM managers.

With the introduction of provisions in the ACA, value derived from integrated complex case management services is projected to transition from primarily health plans and government agencies to networks of physicians setting up ACOs [2, 3, 14, 15]. While there remains great variability in what ACOs actually look like or even in what they are sometimes called, their intent, as outlined in the ACA, is to tap into the expertise of networks of clinicians caring for patients to develop systems of care that improve clinical outcomes at lower total health cost for the population served. ACOs will enter contracts with payers in which they take global risk for outcomes in populations of patients. To the extent that they can decrease total cost of care for the population while maintaining quality and health outcomes, they will benefit from the savings achieved.

Unlike "capitated" contracts in the past, however, the ACOs can reorganize the way that they pay for services from contributing practitioners, such as paying BH providers as part of their medical network. This has already begun as a part of Medicare Shared Savings Programs (MSSP) but is also increasingly becoming part of commercial contracts for nonpublic program populations. Further, with the introduction of health care Exchanges, care delivery systems will find themselves entering global risk contracting for high-risk populations for which profitability can only occur when efficient and effective clinical delivery procedures are used [16]. Health care contracting is projected to move increasingly from fee for service to global risk over the next 5–10 years.

ICM has the potential to play a major role in this ultimate agenda but only if the practitioners treating patients understand how these managers can help and how best to tap into the service support that they deliver. We will try to unfold this as the reader progresses through the *Physician's Guide*.

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