

Chapter 6

Indirect and Direct Physician Support for Integrated Case Management in Adults

To lead people, walk beside them... As for the best leaders, the people do not notice their existence. The next best, the people honor and praise. The next, the people fear; and the next, the people hate... When the best leaders work is done the people say, "We did it ourselves!"

—Lao-tsu

Chapter Objectives

- *To help physicians differentiate the types of assist-and-support services being offered/delivered to their patients.*
- *To clarify physician's roles in relation to ICM and other forms of case management.*
- *To expand on patient triage prior to enrollment in ICM.*
- *To describe what physicians need to know about the ICM-CAG, its anchor points, and the anchored ICM-CAG's relation to the development of care plans.*
- *To explain physician collaboration with ICM managers during iterative case management as patients move to ICM graduation.*
- *To elucidate the synergy between ICM managers and physicians in improving patient health.*

The Physician's Guide is being written to assist physicians and other treating professionals effectively work with ICM managers so that they can maximize long-term health and cost benefits for patients and the system. ICM is an advanced branch of case management, which targets total health improvement in patients, and especially those with health complexity. It can be used to address the needs of patients with selected medical and/or BH conditions, such as occurs in disease management programs, or those with combinations of illnesses. It is effective in both medical and BH settings and patients, but has its greatest value when there is a desire to assist patients regardless of illness combination or location of service. This allows ICM to be used in multiple venues including care delivery systems, such as hospital and clinical systems or ACOs; government programs; employers; health plans; and other companies or organizations that desire to improve the total health of a population and reduce its health-related costs.

Since ICM is not disease-oriented, it can be used effectively for patients with relatively common chronic illnesses, such as diabetes mellitus, bipolar affective disorder, and congestive heart failure, as well as for those with uncommon yet chronic conditions, like amyotrophic lateral sclerosis (ALS), paranoid disorder, or Goodpasture syndrome. While it can be employed in patients with illnesses of low severity and acuity, ICM is especially designed for patients in high clinical need and with high health-related cost. Being applicable for patients with a wide range of conditions and illness severities allows ICM implementation as a unified approach to case management for all clients/patients within an organizational structure.

ICM is not intended to be a quick fix for focused needs of patients, though components of it can be used effectively for such. Rather, it is broad-based and constructed so that ICM managers develop a relationship with their patients and assist them in achieving longitudinal health stabilization or maximum benefit. In most patients, ICM can be completed in several months, though with less complex patients duration of assistance may be measured in weeks. For a small percentage of patients, such as Bob and Elina, correction of barriers to improvement may take the better part of a year. In a few, persistent longitudinal assistance may be required to safeguard health stability.

The construct of ICM is different than assist-and-support work processes specifically devised to impact isolated barriers to improvement. For instance, there are now many transitions of care programs intended to ensure that communication among clinicians and coordinated care is streamlined as patients pass from inpatient to outpatient settings. This is a unique time-specific form of patient healthcare assist-and-support services with evidence of value [1]. It is performed during the several weeks after hospital discharge to prevent the need for readmission and to decrease the likelihood of adverse medical events at a time of high patient vulnerability.

ICM can also address needs arising from care transitions (CHS2 in the ICM-CAG—Coordination of Care) but does not limit its activity to this individual assistance procedure. Rather, through the ICM process, care transition needs are addressed while uncovering and dealing with multiple other barriers to improvement that may be present. ICM's goal is not only to reduce readmissions and post-discharge adverse events but also to help patients stabilize their total long-term health. Isolating single areas of health risk and correcting them, such as care transitions, is core to ICM but fits within the context of a comprehensive prioritized assistance process.

Recognizing these core principles of ICM, how do physicians participate in ICM and contribute to desired outcomes? This Chapter will discuss the role of physicians in relation to four activities, i.e., patient triage, ICM-CAG findings interpretation, collaboration in ICM, and patient graduation. Before addressing these areas, however, a few words will be said about helping physicians: (1) differentiate ICM from other types of assist-and-support services and (2) understand the different roles that they might play when involved with ICM activities.

Table 6.1 Core value-enhancing ICM practices

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- Pre-ICM triaging for patients with health complexity
 - Using relationship-building comprehensive multidomain assessments
 - Correct anchoring of complexity-based ICM-CAGs
 - Building medical and behavioral care plans, based on anchored ICM-CAGs
 - Performing longitudinal iterative ICM with real-time clinical, functional, satisfaction, quality of life, and fiscal outcome measurement
 - Implementing physician-guided escalation of care to reverse barriers and stabilize health
 - Moving patients to self-management and graduation
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Table 6.2 Questions used to differentiate “management” types

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1. Does the manager mainly “approve or disapprove” medical or behavioral services/procedures for patients? If yes, stop!
 2. If not, what are the assist-and-support goals?
 - Assist with a chronic illness, care transition, return to work, other
 - Assist with total health outcomes (medical, BH, both)
 3. On average, how long will assistance and support be provided to the patient?
 - Single encounter, days, months, years
 4. What type of assistance and support is given?
 - Situation/condition-focused assistance, e.g., education, adherence, etc.
 - Clinical and non-clinical assistance
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Differentiating ICM from Other Types of Assist-and-Support Services

Since the majority of assist-and-support activities available in today’s market do not use core-value-enhancing ICM practices (Table 6.1), physicians working with a “case manager” first need to understand what type of assist-and-support services the manager is providing. Terminology that is used to describe case managers, such as care manager, care coordinator, patient navigator, or health coach, does not tell physicians about the actual work processes that will be used or what the manager’s goals are. Current terminology is ill defined, which leads to confusion about what patients and their physicians can expect, both in terms of services and outcomes.

In fact, many calling themselves “case” or “care” managers are really “benefit” (utilization) managers (see Chapter 1) and, thus, do not contribute to improved outcomes for patients. Benefit managers rarely talk with patients. Rather, they adjudicate patients’ benefits. To differentiate benefit managers from case managers, simply ask whether the “management” personnel are *primarily* (50% or greater time allocation) charged with “approving and disapproving” delivery of services to patients (Table 6.2, question #1). Those who do, including many who say they devote only 25–50% time to these activities, are benefit managers regardless of what term they use to describe

themselves. *Additional time need not be spent working with them once medical necessity discussions are complete since theirs is not a “patient helper” role.*

Chapter 1 differentiates patient healthcare assist-and-support programs, based on management intensity and summarizes characteristics associated with each (Table 1.4). In many situations, those performing low-intensity management do not interface with their “client’s” physician. They tend to work in the background, directly with the client, and under the direction of many potential supporters of the low-intensity care management services. For instance, employers may contract with employee assistance professionals, wellness coaches, and/or disability managers to foster improved productivity of their workforce by encouraging healthy behaviors and assisting employees through illness episodes. Most often, physicians have no idea that these managers are even talking with one or more of their patients.

Physicians should generally support such low-intensity managers, even though managers don’t communicate with them or their office staff since they typically support treatment adherence and healthy behaviors. Problems can arise when these managers (and managers providing greater levels of management intensity): (1) raise questions about the appropriateness of treatment or (2) arise from multiple sources of help, e.g., from health plans, employers, and ACOs, all supporting independent but similar manager services at the same time. When either of these occurs, patients and their physicians need to work together to determine which managers are of value and should become part of the patient’s care team and which should not.

Medium-intensity care managers are more likely to contact one or more of a patient’s clinicians. Most often, these managers work directly with patients experiencing active though less acute and severe health problems, e.g., renal failure program managers, workers’ compensation managers, and county caseworkers. To differentiate these managers from high-intensity care managers, additional clarifying questions (Table 6.2, questions #2, 3, 4) can be of help.

Medium-intensity care managers, also called case managers (see Chapter 1), actively interact with patients at discrete time points in their care to accomplish a targeted goal, such as education about a chronic condition and reinforcement of adherence behaviors (disease management), assistance with getting needed procedure approval (workers’ compensation), or supporting end of life services (palliative care). Even when these case managers are not a part of the physician’s hospital and clinic system, they are professionals worthy of physician endorsement to patients. Their job is to foster better patient understanding of illness, follow through on treatment recommendations, and help coordinate clinical services.

Medium-intensity care managers usually interact with patients’ physicians or their staff only occasionally; such as to obtain clarification of treatments and therapeutic goals, since medium-intensity case manager work processes are generally well delineated. When approached, it is a value to the patient for her/his physician or the physician’s staff to collaborate with medium-intensity care manager support though they may not be directly in control of it. To the extent possible, it is well to try to understand the medium-intensity manager’s approach to support and her/his ultimate goals to make sure they are in synchrony with the practitioner’s.

High-intensity case managers, also called complex case managers, deserve the greatest involvement and support from physicians for their managed patients if a

value-added model is used, i.e., one likely to improve health outcomes while conserving or reducing the need to use healthcare services. Complex case managers are more likely to address a broad range of health challenges experienced by the patients with whom they work, to use a longitudinal approach, and to provide clinical and non-clinical assist activities (Table 6.2, questions #2, 3, 4), especially when patients with health complexity are the target population. Models of complex case management, however, vary in:

- How they triage patients.
- What constitutes a comprehensive assessment.
- Whether they address both medical and BH conditions.
- How they perform assist activities and interact with patients, the patient's clinicians, and community support personnel.
- What constitutes success at the completion of the management process.

Thus, before practitioners spend time supporting these potentially valuable resources, it is well to contact the support organizations providing the management in order to clarify the triage procedures, the assessment process, the management activities and average durations, and the targeted outcomes. This will help physicians know whether the complex case management model used for discrete patients is likely to bring long-term improved health with the potential to reduce total health costs. Further, such inquiry will inform the physician about whether she/he can tap into the management support process to augment outcomes in other identified patients with health complexity.

ICM is a subset of complex case management with defined triage recommendations, relationship-based assessment and intervention procedures, standardized care plan development methods, multidisciplinary longitudinal assistance, and measured health outcomes as primary success metrics. Because of the well-defined, value-added features associated with ICM, this Physician's Guide specifically discusses how physicians can maximize results from its use through interaction with and support of ICM managers.

Physician Roles in Actual ICM Management

Physicians may play three general roles associated with the delivery of ICM and other forms of case management. First, they and other licensed practitioners may serve as primary treating clinicians for the various symptoms/ailments/conditions experienced by patients assigned to an ICM manager. Second, they may serve as Medical Directors to the ICM managers assisting patients. And third, they may be providers secondarily involved in specific aspects of a patient's care, such as a surgical specialist or physiatrist, with whom an ICM manager is involved. Each of these has an important role in augmenting the patient experience and improving health outcomes, but physicians in each of these roles must understand how they can collaborate to optimize results.

Treating Practitioners

As discussed in Chapter 1, the practice of medicine is a team sport in today's health-care environment. While the treating physician-patient relationship is at the heart of the care process, physicians and other treating providers are now expected to work with clinical teams to maximize health in populations of patients. Case managers can be part of this team, directly or indirectly. "Direct" case managers are those working within a discrete hospital and clinic system or as employees of a physician group. Employers of direct case managers control the location of service delivery, determine manager workflows and activities, and establish goals and objectives. Often direct case managers work onsite with physicians and patients in their clinics and hospitals. Some bring value. Others do not [2].

A health plan, a business, a government agency, or a patient's family may alternatively support "indirect" case managers. While indirect case managers do not work directly with treating physicians, they may still be of considerable value to patients depending on their employer's approach to care support and assistance. Most indirect case managers assist patients over the phone, i.e., telephonic case management. This is a form of case management that can be efficacious [3-5], about which many practitioners are unaware. Other indirect case managers support patients at or near their place of residence, so called "feet on the street" case managers. This latter approach to case management is most commonly used as a part of public programs since patients with low socioeconomic status often don't have the resources to allow unfettered phone "minutes" or a stable living situation. Going to them is necessary for assistance to be given.

The first step for treating physicians is to ascertain the level of management intensity being delivered by the direct or indirect managers to whom their patients are being exposed, based on the description above (also see Chapter 1). Little time need be spent with benefit (utilization) managers unless it is to advocate for additional services needed by the patient. Low-intensity assist-and-support personnel can bring value to patients but usually do not need assistance or involvement by patients' physicians. Tacit support is all that is required unless negative manager effects are brought to the physician's attention, such as questioning the therapeutic approach or the presence of multiple conflicting managers for the same patient.

Medium-intensity case managers deserve more attention and backing by treating clinicians as long as their objectives are coordinated with those of the treating practitioner and her/his staff. Even isolated gains, such as manager stimulated use of a diabetic diary, support for treatment compliance, or education about a chronic condition can add to better outcomes for patients. Since medium-intensity case managers usually have established workflows, support for these professionals usually does not interfere with a physician's clinic routine. It does, however, require that the case manager have access to needed patient information and endorsement by the treating provider. In return, the case manager should keep physicians, who are actively participating in the patient's care, abreast of what is being done on the patient's behalf along with positive and negative outcomes related to the case manager's involvement.

When a value-added form of complex case management, such as ICM, is identified as the approach being used by a case manager, more active physician collaboration is usually beneficial for both the treatment team and the patient. Value-added complex case managers become partners with physicians in the journey to health for their patients in common. *Physicians diagnose disorders and recommend treatments. Complex case managers help to create a treatment environment supporting execution of treatment plans and achievement of health goals. Complex case managers ensure that care is coordinated and that patients are able to follow through on treatment recommendations; are getting better; and, if not, are moving to the next line of assist activities or treatment.* Thus, physicians and complex case managers should work collaboratively on behalf of the patient to achieve common goals.

This means that physicians should encourage patient cooperation with complex case manager support and supply needed clinical clarification about the patient's health issues and treatment planning. Simultaneously, the complex case manager should share information with the patient's physicians on uncovered clinical and non-clinical barriers to improvement and the assist activities being pursued. Challenges with medication and/or treatment adherence are an example where the case manager may have very helpful information about which the treating clinician is unaware.

Communication and collaboration between physicians and complex case managers is easier when the two are part of the same system, e.g., within an ACO, but this is not always the case. Complex case managers may work for a health plan or a case management sub-contracted vendor's team. Thus, sometimes it is necessary for the physician and case manager to collaborate by obtaining necessary releases of information to share pertinent information verbally and through written/electronic record access. Typically, as part of complex case manager's work routine, permissions, such as those found in the ICM Universal Consent Form template (Appendix N), will also be obtained to support communication among multiple physicians and other providers involved in complex patients' care.

Patients involved in complex case management are commonly those in whom health stabilization has been elusive. Thus, many do not improve with first or even second line approaches to treatment. In these situations, the complex case manager may be charged with documenting whether improvement is occurring and assisting in initiating the next steps needed for "measured" clinical outcomes to occur. They do this in two ways. First, they identify non-clinical factors that may contribute to treatment non-response, e.g., that the patient never filled his/her prescription due to cost or didn't show up for a needed test due to a language-based misunderstanding. When non-clinical factors are involved, complex case managers work with patients (and their physicians) in correcting these barriers.

And second, when non-clinical factors do not appear to be a major contributor to non-response, complex case managers work with both treating physicians and their case management Medical Director (when available) to brainstorm about and adjust the treatment approach as indicated. While the treating physician is the ultimate decision maker in a patient's care, a case management Medical Director can be of considerable assistance by providing fresh ideas about potential intervention options and/or specialty support.

While complex case managers can be of considerable assistance to selected patients, their involvement with patients can also become burdensome to the daily flow of patient care, especially when they compete for patient and physician time with other managers supported by varied patient-outcome stakeholders, e.g., health plans, government programs, or employer groups. In these situations, physicians can become overwhelmed and patients can become confused. From a logistical point of view, it is preferable for complex case managers to be organized through a single source for a discrete population and to use common management procedures understood by treating physicians. When this is not possible, the patients and physicians will need to develop a strategy that maximizes the benefit that case managers can bring.

In many forms of case management and complex case management, treating practitioner participation is not an expectation. Other than occasional sharing of necessary information about the patient and management activities, the two professionals work in parallel to each other but with little direct contact. This is not the case for ICM and its ICM managers. In ICM, open communication and collaboration among the patient, direct and indirect ICM managers, treating practitioners, and other clinical team members is preferred. Communication can be expedited through mutual medical record access and sharing of the ICM-CAG, CP, CPO, and PCIP findings.

ICM differs from many forms of complex case management in that it is measured health outcome, not process, oriented. When expected improvement is not occurring, then both treating practitioners and the ICM manager are important contributors to and accountable for the patient's return to health. Treating physicians and other providers, such as BH therapists or psychiatrists, provide the needed medical expertise to "treat to target" while the ICM manager tackles non-clinical barriers and supports next treatment steps in collaboration with the patient and the patient's clinicians, i.e., "assist to target."

Case Management Medical Directors

In the current traditional "management" environment, program Medical Directors are generally called upon only to support program administration or to assist managers when direct contact with treating providers is required for selected patients. For most Medical Directors, the latter falls in the domain of utilization management where clarification about medical necessity is required. In most case management programs, Medical Directors typically are not as actively involved in patient management activities. Rather, they spend the majority of their time supporting program logistics and answering questions that case managers may have related to illnesses in specific patients. Occasionally, they may also participate in case conferences.

ICM recognizes that nurses, social workers, and case managers from other health professions often do not have the expertise needed to develop assistance and/or treatment alternatives for patients with health complexity based on their level of training and experience. Further, it understands that busy clinicians may be reluctant to work with ICM managers due to lack of understanding about the value that ICM managers bring, or just a heavy workload. Treating practitioners may also bear

hostility toward the location from which the manager is supported, e.g., a health plan. For this reason, *ICM Medical Directors* not only support the ICM program they also provide access to ad hoc physician level expertise and participate in routine review of active ICM manager cases. This allows them to understand clinical and non-clinical patient circumstances and to discuss alternatives when improvement is not occurring.

When adjustments to the therapeutic approach appear worth considering or non-clinical information about a patient would be of value to the patient's treating practitioners, direct provider communication may be considered. This is a particularly important, yet under recognized, contribution found in ICM that is not a part of many other complex case management programs/models. In order to do this effectively, the ICM manager must have defined goal expectations, the ability to measure clinical and functional outcomes, and an ICM support system, including the availability of one or more Medical Directors that allow her/him to identify and receive assistance in moving a patient toward health. Collaboration between ICM Managers and Medical Directors is vital for this "assist and treat to target" component of ICM [6-8].

Using this model, the ICM Medical Director reviews a predetermined subset of the ICM managers' patient panels weekly or biweekly and helps develop alternative approaches to correct unsuccessful assist activities or treatments currently underway. Once the review is completed, the ICM Medical Director may communicate with selected treating providers of non-improving patients to discuss potential helpful options. The treating physician is the one who decides and may initiate changes based on the discussion. While some treating physicians, who do not understand the benefit of ICM, consider this as an intrusion to their autonomy, those with knowledge of ICM and the value of team care realize that the ICM-CAG and Medical Director expertise may expedite achievement of health goals. The ICM process helps to explore alternatives for patients who may not respond to standard treatment protocols. Such mutual effort often can create a "win" for all.

Other Treating Practitioners

In addition to the primary and specialty medical and BH providers making ongoing longitudinal contributions to the patient's care, there will be other physicians or treating professionals who provide expertise, recommendations, and/or interventions, such as medical or surgical specialists, naturopaths, or counselors. While these clinicians may only see the patient occasionally or provide services that may seem extraneous to the focus of case management, they still constitute a meaningful component of care and/or can create dissonance about the treatment approach.

For this reason, they should also understand and be receptive to ICM and other complex case manager queries and, when needed, they should participate in the case management process. For instance, when a patient receives conflicting information from two treating providers, such as a primary care physician and an alternative medicine provider, it is important for the conflict to be clarified, if not resolved, on behalf of the patient. This is often an activity in which ICM and other complex case managers can assist.

Physician's Role in Patient Triage for ICM Assistance

The general principles of triage were outlined in Chapter 2 (see Case-Triggering versus Health Complexity Assessments). Triage itself does not bring value to patients but it is essential for ICM to ensure that patients with the most to gain clinically and economically are preferentially targeted to receive this advanced time-intensive service. Administrative clinician input, including the ICM manager supervisors and ICM Medical Directors, is an important part of this process since they understand the goals of ICM and the number of case managers needed to support the clinical population. ICM Medical Directors can also help to prioritize the patients most in need of services at the time of identification. Administrative clinicians support internal consistency and facilitate direct communication with treating clinicians.

Treating physicians may also participate in the triage process. They are most familiar with the population served, so they may confirm that patients identified by automated case-triggering systems are the best candidates to benefit from ICM services. They may also already have identified patient-specific barriers to clinical improvement, thus contributing valuable information for the initial evaluation. Furthermore, to the degree that they understand that there will not be enough ICM managers to help with every patient, treating physicians can contribute to initial patient database targeting procedures and subsequent clinical algorithms.

It is a combination of administrative clinicians and treating physicians who are most suited to inform the level of rigor that will be used to reduce the total population to the 2–8% of highest risk patients using patient registries, claims databases, predictive modeling tools, and/or complex case-identifying clinical algorithms. When this is complete, informed clinical judgment can then further restrict the number eligible for ICM participation based on available clinical information, treating practitioner experience with the patient, the motivation of and ability to communicate with the patient, and the fiscally based limitation in the number of ICM managers available to deliver ICM services. *Ultimately, the goal is to select those who can benefit most from ICM services, clinically and economically, and to prioritize assigning them to an ICM manager with time to support their care.*

Higher health complexity in ICM manager patient panels limits the total number of patients that can be assigned to a case manager. Further, overextending ICM managers negates potential for health and cost improvement. Thus, an ICM manager panel size should be based on measured complexity of their patient panel, such as with composite ICM-CAG scores. For instance, the average number of total patients that can be carried at a given time by an ICM manager serving a highly complex population subset ranges between 20 and 50. Depending on the number of months that patients are in management, the total number completed (graduated) by each manager in a year ranges from 125 to 250. This would mean two to four ICM managers would be required to serve 5% of a panel of 10,000 patients (500 patients) being treated by a group of five primary care physicians with patient panels of 2000 each.

Because case management is a clinical enhancement that is satisfying for patients and physicians, there is commonly a desire to enroll more patients in ICM than the

number of ICM managers would be able to effectively handle them. For this reason, it is necessary to place strict limits on the total number of patients assigned and managed, presuming that triage procedures are enrolling those with the highest risk and highest need. Further, the management activities of ICM managers should be structured so that patients move toward improved outcomes and “graduate.” This allows them to move on to new cases. As will be seen, real-time outcome measurement documents targeted improvement and ICM-based vulnerability assessments inform appropriateness for graduation using ICM methodology.

Physician Understanding of ICM-CAG Anchoring and Its Relation to Care Plan Development

Physicians and other treating providers do not perform ICM-CAG assessments nor do they create care plans based on complexity findings. They do, however, need to understand the implications of anchored/scored ICM-CAGs, how they relate to the development of individualized care plans, and how physicians can use this information to better treat their patients.

Understanding how to interpret the simple, color-coded ICM-CAG will:

1. Provide new and important information to physicians about patients receiving ICM assistance.
2. Allow them to help their patients derive value from the support services of their ICM manager.
3. Lead to adjustments in their own treatment planning based on additional clinical and non-clinical data.

The ICM-CAG (Table 6.3) is a multidomain comprehensive complexity assessment designed to uncover health-related and non-health-related life circumstances that interfere with a patient’s ability to stabilize their health, i.e., risk factors that predict poor outcomes. Each domain (bio—“B,” psycho—“P,” social—“S,” and health system “HS”) contains five complexity (risk) items: two historical (“H”), two current (“C”), and one vulnerability (“V”). The lettered notations allow use of shorthand to talk or write about the complexity item, e.g., Chronicity=HB1 (historical, biological, first item), Social Support=CS2 (current, social, second item).

Each ICM-CAG item is “anchored” (scored) on a Likert scale from “0” to “3.” Anchor points for the items can be found in Appendix B. During development of the complexity grid and thereafter, researchers from nine countries in Europe went to extensive effort to establish and confirm reliability [9–11] for the scores of each item and the total instrument’s construct validity [12–19]. Further, the ICM-CAG has matured with time so that there is now a self-assessment version [19], versions usable in the elderly [11, 19], and, most recently, a version for children and youth [20].

Initial researchers on the ICM-CAG developed score anchors for each item with the intent that they would lead to potential actions by the patient, the ICM manager,

Table 6.3 Integrated case management-complexity assessment grid (ICM-CAG)

Date	Health risks and health needs					
Name	Historical		Current state		Vulnerability	
Total score	Complexity item	Score	Complexity item	Score	Complexity item	Score
Biological Domain	Chronicity (HB1)		Symptom severity/impairment (CB1)		Complications and life threat (VB)	
	Diagnostic dilemma (HB2)		Diagnostic/therapeutic challenge (CB2)			
Psychological Domain	Coping with stress (HP1)		Treatment adherence (CP1)		Mental health threat (VP)	
	Mental health history (HP2)		Mental health symptoms (CP2)			
Social Domain	Job and leisure (HS1)		Residential stability (CS1)		Social vulnerability (VS)	
	Relationships (HS2)		Social support (CS2)			
Health System Domain	Access to care (HHS1)		Getting needed services (CHS1)		Health system impediments (VHS)	
	Treatment experience (HHS2)		Coordination of care (CHS2)			

Table 6.4 Anchor points for mental health symptoms (CP2)

0. No mental health symptoms
1. Mild mental health symptoms, such as problems with concentration or feeling tense, which do not interfere with current functioning
2. Moderate mental health symptoms, such as anxiety, depression, or mild cognitive impairment, which interfere with current functioning
3. Severe psychiatric symptoms and/or behavioral disturbances, such as violence, self-inflicted harm, delirium, criminal behavior, psychosis, or mania

the patient's clinicians, and/or other stakeholders in the patient's health outcome. This is called "clinimetrics" rather than "psychometrics" since scores translate directly into clinical assistance. For instance, the anchor points for Mental Health Symptoms (CP2) can be found in Table 6.4. A score of "0" indicates that there are no problems with mental health issues. Thus, there are no potential actions for the ICM manager and others involved in the patient's care (Table 6.5); whereas, scores of "1" to "3" indicate progressively more serious difficulties and increased imminence for need of action. In a patient with a score anchored at "3," a wide variety of potential assistance activities in the near future would be considered in the patient's care plan. Anchor point actions associated with CP2 and other complexity items can be found in Appendix O.

Close inspection of the actions associated with complexity items reveals that none involve "treatment" by the ICM manager. ICM managers do not treat patients. They assist patients through "care" plans, not "treatment" plans. On the other hand, many item-related ICM actions include assist activities that foster treatment adherence, measurement of targeted clinical and functional outcomes, and working with

Table 6.5 Potential ICM manager actions related to mental health symptoms anchor points (CP2)

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1. *Mild mental health symptoms*: ensure primary care treatment with stepped access to support from mental health professionals; ensure unfettered access to physical and mental health records by all the treating clinicians
 2. *Moderate mental health symptoms*: Perform appropriate actions under #1; ensure that acute, maintenance, and continuation treatment is being provided by primary care physicians with mental health support and backup; facilitate primary maintenance and continuation treatment provided by primary care physician (medical home) with mental health specialist assistance, i.e., a psychiatrist and mental health “team” (psychologists, social workers, nurses, substance abuse counselors, etc.) when condition destabilizes, becomes complicated, and/or demonstrates treatment resistance; assist with instituting symptom documentation recording system, such as, PHQ-9, GAD-7, etc.; ensure that the crisis plan is available
 3. *Severe psychiatric symptoms and/or behavioral disturbances*: Perform appropriate actions under #1 and #2; include customized actions based on interview; support active and aggressive treatment for mental conditions by a mental health team working in close collaboration with primary care physicians, who care for concurrent physical illness; facilitate use of geographically co-located physical and mental health personnel to improve the coordination of treatment; confirm persistent symptom documentation recording system, such as, PHQ-9, GAD-7, etc.; ensure physical and mental health treatment adherence
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the patient’s clinicians and/or the ICM medical director if improvement is not occurring and escalation of care may be necessary.

In addition to directly promoting physician recommendations, other ICM manager actions target non-clinical barriers to improvement, such as finding funding for medications, helping to find safe housing, connecting the patient with a food bank, or coordinating clinician communication. Reversing non-clinical barriers is often the stimulus for patient adherence to clinical treatment recommendations. For instance, a patient with a poor support system may miss follow-up appointments. Thus, helping a patient find community support resources could improve her/his clinical outcome through better adherence.

With the exception of Mental Health History (lifetime) and Access to Care (last 6 months), anchoring of historical items is related to the last 5 years in adults. Current item scores reflect what has been happening during the last 30 days. Vulnerability is anchored based on the anticipated outcome during the following 3–6 months if ICM management was discontinued.

At the outset of the ICM assessment, the ICM manager uses a scripted dialogue (Appendix C) to anchor complexity items and complete the ICM-CAG. Thus, the dialogue is presented as a “discussion” with the patient that is divided into seven overlapping content areas (Table 6.6). For example, the patient-ICM manager conversation may begin with the statement: “Tell me about yourself,” and the ICM manager may glean information pertinent to scoring several ICM-CAG cells while building rapport with the patient. The ICM manager will be working with the patient for weeks to months. Particularly during the initial evaluation, ICM managers strike a delicate balance between obtaining necessary information and demonstrating compassion and understanding. Unless patients believe that ICM managers care about them and their well-being, the potential for change deteriorates.

Table 6.6 Content areas and open-ended initial scripted questions for adults

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- *General life situation* (1): Can you tell me about yourself, such as where you live, who you live with, how you spend your days, what your hobbies and interests are?
 - *Physical health* (2): How is your (name main medical illness) affecting you today?
 - *Emotional health* (3): How do you feel emotionally, such as worried, tense, sad, or forgetful?
 - *Interaction with treating practitioners* (4): Can you tell me who you see for your health problems?
 - *Health system issues* (5): Can you tell me whether you have difficulty in getting the healthcare you need?
 - *More sensitive personal information* (6): What kind of a person are you, such as outgoing, suspicious, tense, or optimistic?
 - *Additional information from patient* (7): What things did I not ask about that you think are important?
-

The interchange allows a flexible flow of inquiry with the potential for the ICM manager to express empathy and spend time understanding the patient's personal and family issues in addition to illness-related facts. Since it is a dialogue, the conversation is allowed to flow naturally. At the completion of the initial phase of the dialogue, the ICM manager can come back to "missed" items of importance by reviewing the ICM-CAG and connecting items needing scoring with additional scripted open-ended questions.

Finally, the scripted dialogue closes with a request for the patient to give the ICM manager one personal clinical and one personal functional goal that they would like to work toward with the help of the ICM manager as well as their current level of satisfaction with their healthcare and quality of life. These will become the baseline for ongoing health outcome targets, documented in the PCIP, during the course of ICM. It is through personal goals that the patient becomes engaged in the care plan. Satisfaction and quality of life are complementary patient-centered outcomes of importance, core to ICM practices.

Scored items can be entered into the color-coded complexity grid with accompanying notes using ICM software or alternative ICM tools. These should provide a visual that can be shared with and quickly interpreted by patients and their practitioners using the "Understanding Complexity Assessments" explanation sheets (Appendices P and Q). Patients and clinicians may use the ICM-CAG as a tool for reviewing where challenges lie and where assistance might start. The color-coded ICM-CAG's interpretation is intuitive for most. It does not take long to engage the patient, their caregivers, and providers in the next steps.

Since the complexity items are action-oriented, the ICM-CAG can be directly translated into prioritized goals and actions in the form of a written plan of care based on the level of vulnerability and need. At this stage, the treating practitioner's role is to understand the findings reported on the ICM-CAG, to encourage patients to collaborate with the ICM manager, and to stay abreast of progress or failure, contributing to improved outcomes as needed.

Physician Understanding of the ICM Domains

Biological Domain

The Biological Domain targets identification of barriers to improvement related to biomedical conditions. This is the most common focus of assessment and intervention for traditional case management sponsored by non-BH management services. BH management services alternatively target mental health and substance abuse issues found in the Psychological Domain. Table 6.7 summarizes the type of risks and ICM outcome objectives that case managers uncover and address through ICM in this domain. All items within the Biological Domain pertain *only to medical conditions* with the exception of the item titled Diagnostic/Therapeutic Challenges (CB2). For this item, anchoring of a “3” indicates that there is likely one or more non-medical contributor to the persistence of medical symptoms that needs to be addressed, such as depression or treatment non-adherence, in order for the patient to have a successful “medical” recovery.

At this point, readers should spend time reviewing the anchor points and associated actions for items in the Biological Domain (Appendices B and O).

Table 6.7 Biological domain

-
- Chronicity (HB1—last 5 years)
 - Risk—presence of chronic medical conditions
 - CM outcome objective—illness understanding and treatment engagement; consistent and coordinated care
 - Diagnostic dilemma (HB2—last 5 years)
 - Risk—inconsistent or inappropriate treatment
 - CM outcome objective—medical diagnosis clarification and targeted treatment
 - Symptom severity/impairment (CB1—last 30 days)
 - Risk—uncontrolled illness or unnecessary impairment
 - CM outcome objective—stabilized illness and maximum function
 - Diagnostic/therapeutic challenge (CB2—last 30 days)
 - Risk—complicated, invasive, costly, or painful tests or interventions; non-medical contributions
 - CM outcome objective—least complicated, invasive, costly, and painful medical tests and interventions; non-medical contribution reversal; stabilized health
 - Complications and life threat (VB—next 3–6 months)
 - Risk—poor medical outcome if CM withdrawn
 - CM outcome objective—stabilized physical illness; successful patient self-management
-

Table 6.8 Psychological domain

• Coping with stress (HP1—last 5 years)
– Risk—non-productive problem-solving capabilities or handling of stress
– CM outcome objective—stress reduction; improved problem-solving strategies
• Mental health history (HP2—lifetime)
– Risk—history of mental health symptoms associated with impaired function
– CM outcome objective—mental health support and necessary follow-up
• Treatment adherence (CP1—last 30 days)
– Risk—poor assessment and treatment adherence
– CM outcome objective—documented adherence with improved health
• Mental health symptoms (CP2—last 30 days)
– Risk—presence of mental health symptoms/conditions
– CM outcome objective—mental condition stabilization; appropriate level of care
• Mental health threat (VP—next 3–6 months)
– Risk—poor coping, adherence, mental health outcomes if CM withdrawn
– CM outcome objective—-independent ability to handle stress and solve problems, adhere to treatment, and have stabilized mental health symptoms

Psychological Domain

The Psychological Domain does not just assess for BH conditions. Rather, it targets identification of barriers to improvement related to the patient’s coping skills, their mental health history and current symptoms, and their willingness to engage in treatment recommendations. Table 6.8 summarizes the type of risks and ICM outcome objectives that ICM managers uncover and address in this domain.

The Coping with stress (HP1) item evaluates the patient’s ability to identify and solve challenges and deal with stress in their lives. For instance, when this indicator of resiliency is impaired, high scores during assessment may expose use and abuse of recreational substances or alcohol as a means to cope with stress. Treatment Adherence (CP1) assesses the patient’s adherence to treatment recommendations but also attempts to identify and reverse the reasons for non-adherence (Appendix R). This item is often connected to other risk items in the care plan as a result. *Treatment adherence is intended to assess what the patient does, not what she/he says.* Thus, if the patient is not following through on a treatment program even with an expression of willingness to do so, CP1 would be scored “2” or “3” since actions belie what the patient says.

Historical and current mental conditions are recorded using the Mental Health History (HP2) and Symptoms (CP2) items. Along with Barriers to Coping, these two items are commonly omitted from evaluations in traditionally “medical model” case management programs, whereas they are often the focus of attention in “behavioral” case management programs while “biological” items are excluded. When issues, such as depression are identified in patients participating in “medical” case management programs, patients may be transferred to BH managers for assistance.

Table 6.9 Social domain

- Job and leisure (HS1—last 5 years)
 - Risk—financial instability and non-productive personal initiatives
 - CM outcome objective—employment/school and productive leisure activities
- Relationships (HS2—last 5 years)
 - Risk—impaired interpersonal skills
 - CM outcome objective—improved interactions with family, friends, colleagues
- Residential stability (CS1—last 30 days)
 - Risk—unstable or unsafe living situation
 - CM outcome objective—safe and stable living environment
- Social support (CS2—last 30 days)
 - Risk—lack of personal support during times of need
 - CM outcome objective—developed support system
- Social vulnerability (VS—next 3–6 months)
 - Risk—worsening social situation and support if CM withdrawn
 - CM outcome objective—stable social support, living situation, job, personal interactions if CM withdrawn; self-management

The reverse is true for those in “behavioral” programs. Unfortunately, patients commonly don’t or aren’t able to follow through, despite referral [21, 22]. This is the reason that ICM trains case managers with medical or BH backgrounds to assist with cross-disciplinary issues without handoffs.

At this point, readers should spend time reviewing the anchor points and associated actions for items in the Psychological Domain (Appendices B and O).

Social Domain

The Social Domain (Table 6.9) targets identification of barriers to improvement related to life circumstance factors that help a person to navigate adverse health events when they arise. Job and Leisure (HS1) assesses whether the patient has economic stability and/or productive life activities. Relationships (HS2) review the patient’s historical ability to form and maintain friendships, whether with family or in other social settings. Residential Stability (CS1) and Social Support (CS2) assess the patient’s current living situation and support system. All of these directly or indirectly indicate resources that may be available to a patient whose health was compromised or unexpectedly deteriorated. For instance, a middle-aged unemployed and homeless male with diabetic foot ulcers, who only has drinking buddies (HS1 score “3”), is unlikely to be able to follow through on sterile foot care as an outpatient. Without ICM manager help (Social Vulnerability [VS]), he is at great risk for further complications and potential foot amputation.

At this point, readers should spend time reviewing the anchor points and associated actions for items in the Social Domain (Appendices B and O).

Table 6.10 Health system domain

<ul style="list-style-type: none"> • Access to care (HHS1—last 6 months) <ul style="list-style-type: none"> – Risk—poor system-based access to appropriate care – CM outcome objective—insurance coverage; access to needed providers (language, culture, location, etc.) • Treatment experience (HHS2—last 5 years) <ul style="list-style-type: none"> – Risk—mistrust of doctors; adverse experience with care, e.g., drug reaction – CM outcome objective—resolved mistrust issues; identified acceptable providers • Getting needed services (CHS1—last 30 days) <ul style="list-style-type: none"> – Risk—logistical inability to get needed services – CM outcome objective—access to money for meds, transportation, referrals, etc. • Coordination of care (CHS2—last 30 days) <ul style="list-style-type: none"> – Risk—non-communication and collaboration of providers; iatrogenic worsening – CM outcome objective—connection among providers (transitions of care); coordinated care • Health system impediments (VHS—next 3–6 months) <ul style="list-style-type: none"> – Risk—poor access to and/or coordination of care if CM withdrawn – CM outcome objective—persistent access to and receipt of needed and coordinated services

ICM Health System Domain

The Health System Domain (Table 6.10) targets identification of barriers to improvement related to the financing and delivery of care (care complexity) rather than the patient's illnesses themselves (case complexity). In the United States, non-existent insurance coverage or coverage that still makes it a challenge to find needed providers, such as low paying medical assistance or Medicaid, is a major impediment to health (Access to Care [HHS1]). While this and other factors contributing to access problems, such as distance from services (rural medicine) or language, should improve with passage of the Affordable Care Act (ACA), ability to find a qualified physician willing to follow a patient longitudinally will remain a challenge for some years.

Few case management programs assess a patient's trust of doctors or prior experience with delivered medical services (Treatment Experience [HHS2]). Since this is a potential contributor to non-adherence and poor outcomes, it is included in this domain. Getting Needed Services (CHS1), unlike HHS1, refers to logistic challenges that the patient may face in getting needed services or following through on treatment recommendations. For instance, patients with low socioeconomic status may take half of a prescribed dose of an expensive medication to save money. Such practices, unbeknownst to the physician but based on financial hardship, may appear to the treatment team as uncontrolled hypertension or poor adherence to diabetes mellitus treatment. Increasing medication doses, in these situations, will have little effect since financial shortfall predicts continued inadequate dosing and poor control.

Coordination of Care (CHS2) attempts to compensate for care fragmentation in the health system. Assistance with care transitions, such as from the inpatient to outpatient setting, is included under this complexity item. Additionally, this item encourages

communication between medical and BH professionals; discourages unnecessary and/or duplicative tests, procedures, and consultations; and fosters open health record access for all treating providers. Having an ICM manager to connect non-communicating providers can facilitate true improvement of total health. CHS2 differs from CHS1 “coordination” since CHS2 refers to coordination and collaboration among *providers*, whereas, CHS1 refers to coordination of actual services provided, e.g., location convenience, non-conflicting appointments, etc.

At this point, readers should spend time reviewing the anchor points and associated actions for items in the Health System Domain (Appendices B and O).

Physician Understanding of an ICM Care Plan

An anchored ICM-CAG is the roadmap from which ICM managers build their care plans. An example of how this occurs, using the CP, CPO, and PCIP, was illustrated in Chapter 4. Even before these planning tools are completed, however, the scripted interview allows ICM managers to identify measurable personal clinical and functional goals. A patient’s goals are almost always connected to the ICM manager’s and treatment team’s goals. Thus, establishing and using the patient’s goals as a starting point creates ownership and engagement by the patient. The patient and the ICM manager then work together toward a common objective.

After the patient has identified her/his goals, it is then time to vet the accuracy of the assessment, to clarify misunderstandings, and to establish a place to start. Using the anchored color-coded ICM-CAG is ideal for setting this process in motion. It is easy to understand with minimal instruction (Appendices P and Q) and can be employed with both the patient and the patient’s clinical team. Further, the physician should be informed of the patient’s goals so that all will be working for a patient-centered purpose. Other prioritized goals should be developed and shared with all stakeholders when input is sufficient to allow the writing of a plan of care.

When the ICM manager, in collaboration with the patient, completes the care plan, physicians may find it helpful to discuss findings on the ICM-CAG directly with the patient. Such a discussion may help clarify previously unknown issues related to care and help the patient recognize that the physician and ICM manager are a cohesive unit. Ways in which the physician may be additionally helpful for the patient may also be illuminated, possibly enhancing trust and engagement in the care plan.

Physician Understanding of the ICM Management Process and Patient Graduation

Much like the diagnosis and treatment of disease, ICM is an iterative process designed to overcome identified barriers to improvement. As previously discussed, barriers to improvement are clinical and non-clinical health and life circumstances that are associated with impairment of a person’s ability to adhere to healthy behaviors or to follow

through on activities that lead to stabilized health and maximal function. In a true sense, physicians and ICM managers are partners in the healing process. They just address different aspects of patient challenges in achieving health.

Completion of the ICM-CAG is a starting point for patient assistance and often does not focus on biomedical factors as the place to launch. This is because non-clinical factors frequently prevent a patient from following through on clinical evaluations and treatment recommendations. The ICM-CAG is able to capture and prioritize non-clinical factors in the context of clinical factors for which primary responsibility rests with treating physicians. Importantly, the ICM-CAG identifies areas in the patient's situation that need action. Findings on the ICM-CAG should be of interest to all treating physicians.

For instance, a physician who had been working with ICM managers for some time noticed that a long-term patient with cystic fibrosis was having considerably more challenges in controlling her illness during the previous several months. Initial attempts at reinforcing pulmonary toilet procedures and medication adherence did not seem to alter her condition. An ICM manager was assigned and able to identify that the patient had depressive symptoms (CP2) and was also preoccupied with providing health support for her sick mother (CS2). As a result, she was not following through on the percussion and drainage or using her inhaled medications as recommended for control of the cystic fibrosis.

The patient had been seen in the emergency room several times during the previous month and was admitted on one occasion with pneumonia. While the physicians involved in her acute care attempted to reinitiate appropriate medical treatment, it was not until after the case manager helped the patient set up support services for her mother and shared information about contributing depressive symptoms with the patient's doctor (who initiated treatment) that steady improvement of the patient's lung disease was possible. This example shows how ICM managers can support simultaneous attention to medical and BH aspects of treatment, as well as clinical and non-clinical barriers to care, leading to improved health outcomes.

The CP (Appendix F), a gradually maturing plan of care, and the CPO (Appendix G), a timely appraisal of success in improving outcomes for items listed on the CP, are an ongoing record of actions taken by or on behalf of patients and their success in focal goal achievement. Examples can be found in Tables 4.8 and 4.10. These instruments document progressive management activity being supplied to the patient.

The CP starts with items on the ICM-CAG that have been documented to have high priority (scored 3 [red]). Sometimes "red" items are connected to items in other cells with lower scores, such as when a person has serious acute manifestations of her/his medical illness due to lack of adherence to indicated interventions ("red" on CB1 and "orange" on CP1). ICM assessment may also uncover a comorbid mental health condition that has remained untreated. While the mental health condition may be low grade (scored as "yellow"), it nonetheless could be a significant contributor to non-adherence and poor medical improvement.

In the above scenario of the patient with cystic fibrosis, CB1, CP1, CP2 are connected as an area of ICM intervention. The initial goal might be "absence of depression" by assuring that outcome-changing treatment for depression is provided either

by the primary care physician or a mental health professional. The long-term goal would be “stabilization of the patient’s chronic medical condition.”

The CPO merely adds a third column to the CP, i.e., an outcome column. This allows the ICM manager to periodically return (days, weeks, or months depending on the desired goal) to the CP initiative and assess whether the initial goal and then the long-term goal have been achieved. Of course, the ultimate goal of stabilized health in the case described above may also require further testing, adjustments of medications, finding specialist assistance, or improving communication among practitioners. That is why the CP is iterative and incremental. When directed actions have not achieved desired goals, then the next steps are taken as part of an updated care plan or goals and expectations are adjusted.

The ICM manager uses the CP and CPO to systematically move from high-priority barriers to improvement to less serious ones until the patient is considered sufficiently stable to return to standard care. This is called “graduation” from ICM. At the time of graduation, the ICM manager reinforces with the patient, in coordination with the patient’s clinicians, the application of personal initiative and preventive measures that support self-sufficiency in a standard care environment.

Graduation, alternatively called “becoming inactive in ICM,” is a time of high vulnerability for the patient. By this time, the ICM manager and patient have developed a relationship. The patient appreciates the benefit from ICM manager assistance and is reluctant to lose this source of support. Thus, ICM places special emphasis on the steps that need to be taken in transitioning from active ICM to standard care. This involves preparing patients for the transition by congratulating them on their success and going over the steps that they and their primary physicians will continue to monitor in the future. It is during this time that treating clinicians are also informed of imminent graduation and are given copies of the initial ICM-CAG, a current state ICM-CAG, the final PCIP, and a summary of areas of challenge for the patient as they return to standard care.

The PCIP (Appendix S) is an evaluation of the longitudinal “big picture” as patients progress through ICM assistance. It monitors and records measured changes in five major areas of outcome interest. An example of a completed adult patient PCIP can be found in Table 4.12. It is the PCIP that demonstrates the overall success for the patient through ICM intervention. Further, it can be used to record the success of the ICM program for a sponsoring organization/company. Composite outcomes can be standardized, aggregated, and then analyzed for individual ICM managers and for the program as a whole.

Physician and ICM Manager Synergy

ICM is intended to augment clinical treatment from a physician by assisting in health and life circumstances that interfere with patients’ ability to improve and stabilize their health. Treating physicians maintain a focus on clinical evaluation and treatment. Physicians working with patients having an ICM manager, however,

have the advantage of quick access to information not typically included in standard medical assessments as well as intervention capabilities for circumstances that impede treatment outcomes.

To the extent that the physician and ICM manager see themselves as a team for the patient, physicians will incorporate into their treatment plans an improved understanding of non-clinical factors affecting their patients' health outcomes that have been uncovered through the ICM assessment process. For instance, knowing that a patient is not taking full doses of needed medications due to financial challenges allows a physician to consider cheaper generic alternatives or to seek medication cost support programs rather than simply increasing the dose of an expensive medication on the presumption that the current dose is insufficient to effect change. It is through enhanced information sharing that improved outcomes can be achieved.

On the ICM manager's side, it is necessary for the treating physicians to support and encourage engagement in the ICM program. Support comes in the form of clinical information sharing and communication with the ICM manager. Perhaps more important than this, however, is the endorsement that the physician gives to the program from the eyes of the patient. Patients respect their physicians and look to them for guidance in the types of activity they should pursue in an effort to maximize health. To the extent that patients understand that their physicians and ICM managers are working as a team on their behalf, they are much more likely to invest in the time and effort needed for health improvement to occur.

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