HOW CASE MANAGEMENT OPERATES IN AN INTEGRATED HEALTHCARE SYSTEM

Case Management Evolution

Presented with and committed to serving populations in need of sustaining care, case management was initiated in behavioral health centers. Seriously mentally ill adults, developmentally disabled people, and emotionally disordered children need their care managed. In most mental health services, used of licensed providers was too costly and often did not fit their interest or expertise. The choice was to use helping and supportive staff to establish a relationship, support the patient in their daily living choices, and link them to needed resources.

Knowing that structured and scheduled services did not reach many of the patients with multiple needs and disordered lives, centers asked case managers to manage the most complex and high-risk patients. Often they were asked to do this outside the office structure and on their own. While given some guidance by a plan of treatment that was usually disease focused, they faced the challenge of minimal resources and lack of evidence-based practices to assure best possible outcomes of their case management. They were often left to their own devices to meet the needs of the patients. If the patient followed through for an appointment or applied for an additional service, the case management was considered a success. To make matters more complex, case management positions generally have the highest turnover, the lowest rate of pay, and the least amount of clinical training and skills.

Recognition of these challenges and feeling there was a better way led to the application of best practices and the development of Assertive Community Treatment (ACT) and the formation of ACT Teams. Patient challenges were too complex, persons monitoring outcomes were not impressed, and there are applicable best practices. It was no surprise that case management needed to be well defined, supported with training, and have clinical protocols. At the same time ACT was being promulgated, the Recovery movement was taking hold as a recognized and valuable approach to meeting the needs of the seriously mentally ill. Two additions to the mix occurred. One was the idea that the patient is responsible for managing their life and that peers are a valuable support. Others who have “been there and done that” were enlisted for support. In some centers Peers were employed to help other peers. The combination of ACT and peer as case managers elevated case management in its evolution. When it is at its best it is faithful to best practices and assists the patient in navigating the complexities of their disease.

In 1998, the Robert Wood Johnson Foundation convened a consensus panel of researchers, clinicians, administrators, consumers, and family advocates to discuss the research and to determine which practices currently demonstrated a strong evidence base. Six practices were identified:

- standardized pharmacological treatment
- illness management and recovery skills
- supported employment
- family psycho-education
- assertive community treatment
- integrated dual disorders treatment (substance use and mental illness)

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) developed Evidence-Based Practice Implementation Resource Kits for case management practitioners. These kits contain useful resources and represent the maturity of case management within the behavioral health arena.*

Case Management Redux

Then came the challenge of integrated primary and behavioral health care and with it the challenge of rethinking case management. Primary care is oriented to using standardized care and decision making for common conditions or combination of conditions. The reality is that some patients do not engage or respond as they should in the view of the clinician. Peek, Baird, and Coleman ** in their article on *Primary Care for Patient Complexity, Not Only Disease* explores in a helpful manner the challenges of treating the "complex" patient and lays the ground work for a new form of case management.

Most evidence-based protocols are focused on versions of standard care and decision making for conditions. This now includes behavioral conditions as well in an integrated setting. The glasses we wear focus us on thinking about care through disease categories: asthma, depression, diabetes, and etc. as well as coexisting combinations. Working together in an integrated setting is supported and aided by having routine and reliable care for commonly occurring conditions. The problem is that it does not work for some patients. They tend to be described as complex. Peek, Baird, and Coleman quote a physician's remarks when reflecting on a complex patient.

> *"Complexity is what I feel when I don't have an algorithm for what's in front of me. And why don't I have an algorithm for complex patients? Because our algorithms are for diseases, not persons."*

When it comes right down to it care and decision making is geared to conditions. The authors do us a further service by identifying familiar outward signs of unmanaged complexity while the specific factor remain hidden:

- Many doctors, diagnoses, and visits—especially if unfocused or redundant;
- Many and/or redundant medications, services, diagnostic tests or failed services;
- Unplanned clinic and ER visits; number and length of hospital admissions;
- Patient involvement in multiple helping systems such as clinics, public health services, and social services;
- Difficult patient/clinician relationships; and
- A large gap between patient's and clinician's view on how severe the symptoms are—or are expected to be.

The authors also propose a definition for patient complexity which begins to define the context for case management in an integrated care setting. It is defined as the person-specific factors that interfere with the delivery of usual care and decision-making for whatever conditions the patient has. The definition of complexity seems to partially write the script for case management. The initial step is to identify the person specific factors that are interfering. Needed is a an approach that identifies the critical domains impacting the patient and an assessment of the level or intensity of the impact of the specific domain.

Again Peek, Baird, and Coleman present a complexity assessment method that tracks five domains:

1. An illness domain that includes diagnostic uncertainty and functional impairment due to

symptom severity;
2. A readiness domain that includes distress, distraction, and readiness to engage treatment;
3. A social domain that includes participation in the social network and home safety and stability;
4. A health system domain that includes organization of care and patient clinician relationships;
5. A resources for care domain that includes the degree of shared language with providers and the adequacy and consistency of insurance for care.

These domains are then assessed for severity (see Figure 1). Each domain represents a separate source of complexity and if rated high, it signals an area that likely needs to be addressed as an area of interference. The purpose of the assessment is for action and not another way to describe the situation. It helps define the areas that need attention, whether it is by the clinician, the case manager, or the client. For those whose case needs to be managed, the plan of action is a blueprint for those who need case management. When there are significant sources of complexity, a plan needs to be formulated and decision made as to who does what. Use of the assessment method should be triggered by and of the outward signs listed above, administered by a case manager, and presented to the responsible clinician. For those patients with moderate or very complex situations, case management should be initiated. Persons trained in behavioral health can be excellent resources for this function. Those trained in the best practices of ACT understand the complexity of issues facing a patient and have skills to help them address the challenges.

A New Case Management Model

A new era of integrated care is inviting a new model of case management. And just like the early case management era, the complex patients are the ones prompting our rethinking of how we work. Integrated care calls for:

- Planning for care for persons in all our complexity and not just for diseases or combination of diseases
- Person focused complexity assessments
- Bio-psychosocial integration
- Getting beyond “solo” acts of care
- Linkages social and community resources

The case manager can play an essential role in the action plans for the treatment of the complex patient. They can bring the skills of relationship building, teaching recovery skills, linkage to resources, family education, and care coordination. They can be a valuable assess to the treatment team, help reduce the frustration of the clinicians with complex patients, and incorporate acting on patient specific complexities into practice based care coordination.

In any redefinition of a function or role challenges always emerge.

- Clarity of role definition and acceptance by the treatment team.

- Definition of skill and level of training required. What level of skill is needed and what level of training or licensure is required?
- Scope of work is expanded over disease focused care.
- Identification and use of the most applicable best practices.
- Sufficient stability of employment to sustain the necessary relationships with social and community resources.

Addressing the patient's complex set of needs so that they are able to avail themselves of the healing processes is the function of the new case manager. They can lead the effort to identify the sources of complexity and bring resources to bear that will help the patient be able to use the medical care offered. This will lead to better outcomes, reduction in wasted and inappropriate services, and patients successfully managing their lives.

References

* Substance Abuse and Mental Health Services Administration (SAMHSA). Center for Mental Health Services. National Mental Health Information Center. *Evidence-based Practices: Shaping Mental Health Services Toward Recovery. (2003).* Available: www.mentalhealth.org/cmhs/communitysupport/toolkits/community

** C. J. Peek , Macaran A. Baird , Eli Coleman , (2009) Primary Care for Patient Complexity, Not Only Disease. *Families, Systems, & Health Vol. 27, No. 4*, 287–302

FIGURE 1 PEEK, BAIRD, AND COLEMAN

Minnesota Complexity Assessment Method

Patient:	Age / gender:	Problem:

Domain	Current state of affairs	Complexity level			
Illness Biomedical, mental health, and chemical dependency symptoms & diagnoses	**Symptom severity / functional impairment**				
	0=No symptoms; or reversible w/out intense efforts	0			
	1=Mild noticeable sx; don't interfere w function		1		
	2=Mod to severe symptoms that interfere w function			2	
	3=Severe symptoms impairing all daily functions				3
	Diagnostic challenge				
	0=Diagnosis(s) clear	0			
	1=Narrow range of alternative diagnoses		1		
	2=Multiple possibilities; clear dx expected later			2	
	3=Multiple possibilities; no clear dx expected				3
Readiness to engage	**Distress, distraction, preoccupation w sx.**				
	0=None	0			
	1=Mild, e.g. tense, distractible, preoccupied		1		
	2=Moderate, e.g. anxiety, mood, confusion			2	
	3=Severe w behavioral disturbances, e.g., harm				3
	Readiness for treatment and change				
	0= Ready & interested in tx; active cooperation	0			
	1=Unsure/ambivalent but willing to cooperate		1		
	2=Major disconnect with proposed tx; passivity			2	
	3=Major disconnect; defiant/won't negotiate				3
Social	**Current home/residential safety, stability**				
	0=Safe, supportive, stable	0			
	1=Safe, stable, but with dysfunction		1		
	2=Safety/stability questionable; evaluate/assist			2	
	3=Unsafe/unstable; immediate change required				3
	Participation in social network				
	0=Good participation with family, work, friends	0			
	1=Restricted participation in 1 of those domains		1		
	2=Restricted participation in 2 of those domains			2	
	3=Restricted participation in 3 of those domains				3
Health system	**Current organization of care**				
	0=One active main provider (medical or MH)	0			
	1=More than or less than 1 active provider(s)		1		
	2=Multiple medical / MH providers or services			2	
	3=Plus major involv. with other service systems				3
	Patient-clinician (or team) relationships				
	0=All appear intact and cooperative	0			
	1=Most intact; at least 1 distrustful or remote		1		
	2=Several distrustful or remote; at least 1 intact			2	
	3=Distrust evident in all pt/clinician relationships				3
Resources for care	**Shared language with providers**				
	0=Shared fluency in language with provider	0			
	1=Some shared language / culture with provider		1		
	2=No shared language; professional translator avail.			2	
	3=No shared language; family or no translator				3
	Adequacy / consistency of insurance for care				
	0=Adequately insured, can pay for meds, copays	0			
	1=Under-insured with modest other resources		1		
	2=Under-or intermittently-insured			2	
	3=Uninsured, no other financ. resources for care				3

Instructions:

As you gather information and listen to the patient,

- Scan for sources of complexity (interference with usual care) on the left.
- *Ask questions* that help you understand what you don't know.
- *Circle a level* that reflects your understanding of complexity in each area.
- *Outline a plan of action* that takes into account the observed pattern of complexity

Plan of action:

General goals:
(For both complexity and diagnosis)

Self-check: Do I need someone in this case with me; and who?

Team / roles required:
(Who does what; how it adds up)

Patient / family role (as part of the team):

What clinician / team will do today:
(To act on both complexity & diagnosis)

No complexity; only routine care needed
No evidence of need to act (beyond routine care)

Mildly complex; basic care planning needed
Watch / prevent; explore interacting issues

Moderately complex; multifaceted plan needed
Form a well-integrated plan; set in motion

Very complex; intensive care & planning needed
Consider immediate, intensive, integrated action

With all your ratings in view, decide what level and kind of action is needed in what areas; and incorporate that into your action plan.

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Figure 1. Minnesota Complexity Assessment Method.

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