Issue Brief

The Elements of Integrated Care Management

National Chronic Care Consortium

Since the National Chronic Care Consortium (NCCC) was established in 1991, members have been committed to building chronic care networks—systems of care which better meet the needs of persons with chronic conditions. The vision of a chronic care network (CCN) has been guided by the four interrelated cornerstones of CCN development: integrated care management, integrated systems management, integrated information systems, and integrated financing systems. Experience has repeatedly confirmed the need for all four of these elements to work well if the CCN is to effectively serve chronically ill clients.

The care management component of CCN development has been of special importance to the NCCC. Care management personnel often provide the impetus for a system's focus on integration and chronic care, because people providing care management services see firsthand the problems associated with a fragmented system and the potential benefits of integrated care.

While all NCCC members are working to improve their ability to provide integrated care management, each site is at a different stage of evolution, serving different types of populations under a different set of circumstances and structures. Despite the variation among the sites, NCCC members have come to a consensus on defining the basic elements of integrated care management, which we describe in this article. Many NCCC members will recognize familiar concepts and figures contained in this *Issue Brief*. In examining the nature of care management, this primer builds upon previous work and incorporates the NCCC's more recent learnings, including work from the Self-Assessment for Systems Integration (SASI) tool. Information has been gleaned from NCCC member presentations made during the NCCC's national conference, the NCCC's bimonthly resource, *CareLink*, and other documents and resources of the Consortium.

Case Management and Care Management

A discussion of integrated care management is perhaps best begun by articulating the differences between care management and the more familiar concept of case management. Case management has been an important part of providing care to chronically ill people for decades. Traditionally, case management refers to a case manager's work of assessing a client, arranging a set of services to meet client needs, and monitoring a client's progress over time, making changes in services as necessary. Case management began to help clients—particularly frail, older clients headed for a nursing home—negotiate a confusing array of health and long-term care service alternatives and avoid institutionalization.

While recognizing the many benefits of traditional case management, the NCCC focuses on the broader concept of *care management*. Integrated care management refers to systemwide efforts within a healthcare organization to assure that clients receive services that are appropriate to their needs, integrated across service settings and over time, and that support client and systemwide goals.

The NCCC defines integrated care management as

> the policies, procedures, tools, and practitioners a chronic care network uses to organize services for persons with chronic conditions across all network settings.

Key elements of integrated care management include

- providing person-centered care,
- emphasizing disability prevention,
- integrating a full array of services,
- targeting high-risk populations, and
- using interdisciplinary care teams and related tools and processes.

Traditional Case Management	Integrated Care Management
Focuses on developing a plan of care with intervention at a specific point in time, e.g. hospital discharge.	**Provides person-centered care** throughout a condition's evolution.
Emphasizes offering care in the least restrictive setting.	**Emphasizes ongoing disability prevention** regardless of setting.
Coordinates services from a variety of unrelated service settings.	**Integrates a full and flexible array of services** across a variety of network and other linked settings.
Targets people at risk of near-term institutionalization, usually nursing home placement.	**Targets people at high risk** of disability progression and high cost care.
Case managers usually have no authority over care providers.	**Uses tools and interdisciplinary care teams** empowered to manage care across settings.

Provides person-centered care

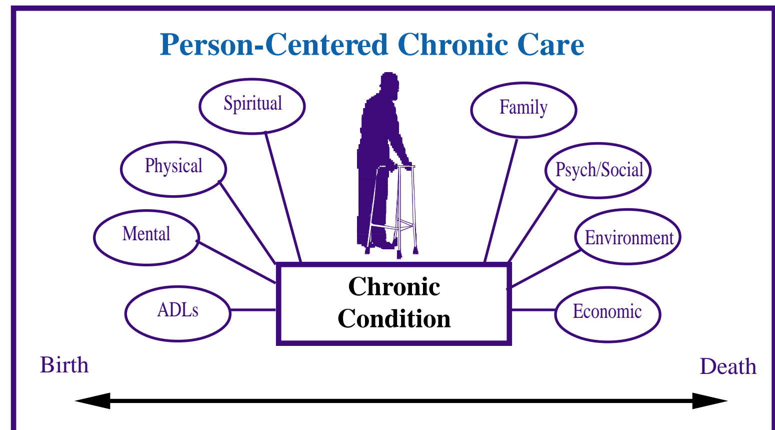
Person-centered care–also referred to as patient-centered or client-centered care –permeates all aspects of an integrated chronic care network, including care management.

As articulated by Rosita Schiller, the patient-centered paradigm includes the following concepts. Care is designed to

- minimize the movement of patients across settings,
- increase the time professionals devote to clinical care,
- reduce the number of individuals with whom the patients interact,
- streamline paper work, and
- tailor environments to patients' needs.

These components are vital in chronic care, where clients frequently move from one setting to another over time in order to receive the ongoing care they need.

For a CCN to provide person-centered care, it must be responsive to client issues, involve the clients as care partners, and take a holistic view of the client.



Responsiveness to client issues

Person-centered means the characteristics of the healthcare system directly correspond to the major issues of the people to be served. It means that rather than the person responding to the requirements of the system, the system must respond to the requirements of the person. In chronic care, the critical dimensions of importance for systems' responsiveness relate to five characteristics of chronic disease: multidimensional, interdependent, disabling, interpersonal, and ongoing.

Clients as care partners

In a person-centered CCN, clients are involved in care management and self-care activities. CCNs involve clients first by recognizing the client as the primary care manager and then by promoting client choice and educated participation in addressing client needs. Care management personnel consult with clients in care plan development, implementation, monitoring and follow-up, and promote client self-sufficiency in understanding their conditions and related self-care.

A holistic view of the client

Person-centered care means taking a holistic view of the client, recognizing that chronic care is multidimensional in nature, affecting and being affected by many aspects of an individual's life at the same time and over time. These variable aspects of a client's life need to be considered in all stages of care management. Spiritual, mental, economic, and social factors must be considered in addition to the traditional issues of physical helth and functional status.

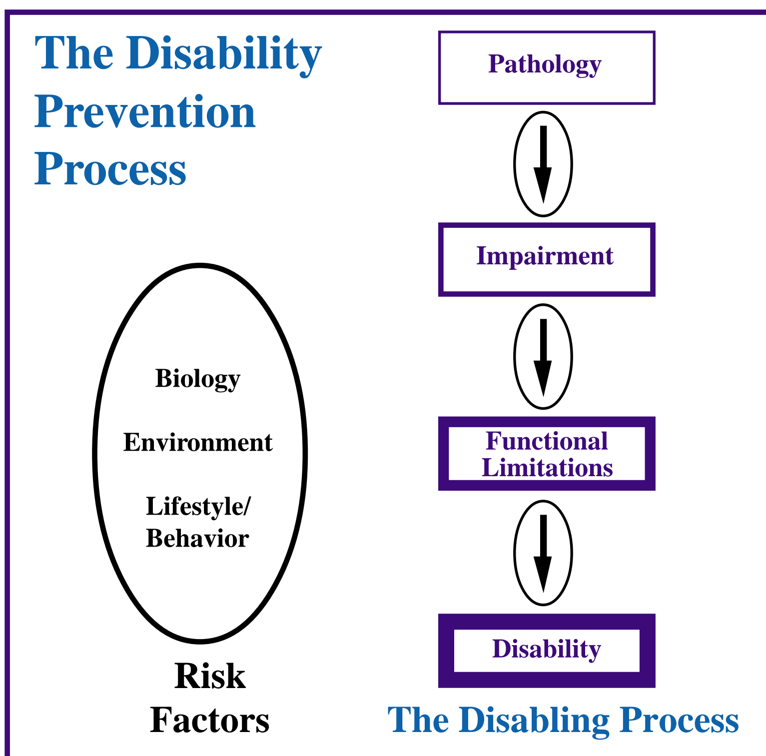
Person-centered care also means working within the context of family and community. Family caregivers and other supporters, such as neighbors and friends, assume a central role in the health and well-being of the person in need during the later stages of any chronic condition.

Emphasizes ongoing disability prevention

Society's cure-oriented, crisis approach to planning and treatment in healthcare has resulted in remarkable improvements in acute care and our overall quality of life. However, it has also caused a focus on end-stage healthcare, to the extent that the cost effectiveness of primary care and disease and disability prevention is often ignored. Preventing, delaying, or minimizing the progression of disability is a critical function of integrated care management. CCN purchasers, payers, and providers must strive to keep this focus when making decisions, especially quality and cost decisions.

The disability prevention process

One of the primary concepts the NCCC uses in understanding and applying disability prevention strategies to chronic care populations is the disability prevention process. In this process, disability is viewed as progressing through four stages. These stages, as developed by the Institute of Medicine (1991), are pathology, impairment, functional limitations, and disability. At each of these stages, risk factors pertaining to the biology, environment, and lifestyle/behavior of the person can affect the degree of disability. At each stage, providers and clients work to avoid, delay, or lessen the level of impairment, functional limitations, and eventual disability arising from the condition.



Interventions

NCCC members talk about three levels of disability prevention: primary prevention, secondary prevention, and tertiary prevention. Primary prevention focuses on helping clients to avoid the condition in the first place. Secondary prevention slows the rate of decline and works to avoid disability from the condition. Tertiary prevention helps avoid complications from the condition and maximizes function and quality of life.

Consider clients with hip fractures. CCNs can work at all stages of this condition to prevent disability progression. For example:

- Screen clients for osteoporosis long before problems develop, advising necessary changes in diet and medication.
- Assist clients in assessing their environments for hazards.
- Use extended care pathways and other methods to prevent clients from developing complicating conditions.
- Assure a smooth transition from the hospital to other settings, arranging for in-home supports and teaching self-care.
- Ensure that clients who need long-term institutional stays following a hip fracture are treated appropriately to prevent depression, bed sores, or other complicating problems.
- Involve, to the degree possible, clients who are facing death as partners in making care decisions and work with them to prevent unnecessary pain or confusion.

Integrates a full and flexible array of services

CCNs are committed to providing a full array of chronic care services that allow for easy access and smooth transition. This array allows a CCN to

- meet individual needs,
- promote client choice,
- use cost-effective/least restrictive alternatives.

Easy access to services

A key element of integrated care management is easy client access of services across settings. That is, a CCN's written polices and procedures should support a client's ability to both access services from any point within the system and receive services from any other component part, with a minimal disruption to the client's course of care. A person can access long-term care from the offices of primary care physicians. A person can obtain information on health promotion in any acute or long-term care setting. Although there may be a common office that coordinates all information services, every program contains information on every other component of the care continuum and makes the information readily available to people served. Person-centered care requires a multiple, equal access service orientation.

Smooth transitions

Integrated care management also ensures smooth transitions between related care settings. Whenever a person needs services from more than one program, either at the same time or in sequence, the process used by those programs functions as a single system. Care planning does not begin at the front door and end at the back door. Providers do not admit or discharge clients, but offer a smooth transition between places and programs where care is provided.

For example, if an individual leaves the hospital and receives short-term nursing home care after a hip fracture, the individual experiences this as simply leaving one setting and going to another, rather than a discharge from one system and the admittance to a separate system. The same care management team follows the individual across settings, discharge/admittance procedures are eliminated, and duplicate assessments are minimized. Providers do not repeatedly collect client information about problems being addressed and services being provided. People receiving care move from one program to another without disruption in their care. All programs function as part of the same care team.

The integration of short-term care services within an overall continuum is particularly important, as it provides continuity of care when a patient's medical and functional conditions are most volatile, and it optimizes the rehabilitation potential of clients served. Short-term care starts when a person's *medical* condition begins to stabilize following the onset of an acute episode of a disabling condition and ends when a person's *functional* condition is stable—whether that is in a home or nursing home. Short-term care services include inpatient transitional care, rehabilitation services, adult day care, short-term home care, self-help technologies, and specialized services.

Successful integrated care management requires a full continuum of services to be available to chronically ill people. A "full continuum" of services is broad in both concept and reality; it includes, but is not limited to:

Primary Care

Acute Care

Preventive Care

Transitional Care

Rehabilitative Care

Long-term Care

Palliative Care

Home Health Care

Self-Care

Subacute Care

Primary, secondary, and tertiary prevention services

Chronic Care Medical Direction

Specialized Diagnostic Centers

Adult Day Care

Skilled Nursing

Housing

Caregiver Support Services

Drugs

Medical Equipment

Transportation

These services are integrated rather than coordinated in that all these network components work as a unified whole to meet systemwide goals.

Targets people at high risk

CCN care management activities focus on persons at high risk of disability progression and high cost care, where interventions can make a real difference in client outcomes and/or system costs. Risk identification (Risk ID) is an ongoing process aimed at enabling healthcare providers to identify and manage the health risks of consumers and prevent disability or delay further deterioration. It is a mechanism for providing quality service while minimizing cost.

Targeted populations may include people at high risk of a particular adverse outcome and persons with (or at risk of getting) a particular chronic condition. Examples include people age 85 and over, people with AIDS, people lacking social supports, people who are nursing-home eligible, people with Alzheimer's disease and related disorders, and people who are dually eligible for Medicaid and Medicare.

For a more complete discussion of Risk Identification, you may purchase *Risk Identification: Exploring a Conceptual Framework and Identifying Implementation Issues* for $50.

Call the NCCC at (612) 858-8999 for information.

Identifying risk

As an integrated care management activity, risk identification can be comprehensive, spanning issues of health promotion and wellness, as well as chronic disease, illness, and disability. Risk identification can also be specific, identifying persons at risk of using high-cost acute and long-term care services. Both a comprehensive and a specific approach are important for quality and cost-effective service. In the short term, addressing the risk for high-cost care is a priority, with the possibility of immediate reward for the network and high-risk consumers. The cost/benefit trade-offs of Risk ID and early intervention are well-documented for high-risk groups. Over the long term, risk identification will allow payers and providers to target low-risk groups and decrease the number of people who progress to chronic illness and disability.

Risk identification begins at enrollment in a health plan, or at the earliest point possible if there is no health plan in place. Although the starting point for identification may differ, the goal is common: to group people according to their similarity of risk in order to intervene and modify risk factors (e.g., prevent disability or lessen the rate of functional decline).

Addressing needs

After high-risk populations have been identified, CCNs use a variety of methods to specifically address client needs. These methods, which strongly emphasize disability prevention, include

- extended care pathways and guidelines that are condition specific;
- interdisciplinary care teams that have expert knowledge of a given chronic condition;
- information and financing systems that document and support the costs and outcomes associated with specific chronic conditions;
- self-care, educational, and other materials that are specific to the needs of clients with a particular chronic condition.

Risk identification is only as valid and reliable as the tools and analyses employed in the process. Payers and providers are therefore increasing their efforts to develop effective screening tools. Yet they quickly discover risk identification alone does not ensure success; the biggest challenge is aligning the health provider's work with the client's perspective of risk and willingness to take action to reduce risk. Over time, the more parsimonious the risk identification process, the more cost-effective it will be. With rigorous and ongoing review of the process, providers and others should be able to increase the specificity of the relevant risk groups as well as the interventions that yield the best outcomes.

Uses tools and interdisciplinary care teams

To provide effectively for the chronically ill, CCNs need explicit care management models that link professions and disciplines and that enhance care coordination over time and across settings. Interdisciplinary care teams and extended care pathways may serve as methods in helping this to occur.

Interdisciplinary care teams

Since chronic care affects so many aspects of an individual's life over time, CCNs rely heavily on interdisciplinary teams. Team members bring their unique perspectives and expertise to meeting client needs and preferences. Having various disciplines working together is often the only way the CCN can assure a holistic view of the client and smooth transitions between settings. Often these care teams include the client, and sometimes the caregivers. In some CCNs, a centralized care team manages all care provided throughout all settings. In others, the centralized team simply monitors care to ensure continuity of care. Increasingly, the care team is empowered to make binding decisions regarding the client's care.

Building upon the capability of primary care is essential in interdisciplinary team planning. Virtually every chronic condition has an underlying associated disease or medical problem. The doctor's office is often the first place people go to find solutions to their health-related problems.

Who serves on a care team may vary. A care management team might be composed of

- the client,
- primary (informal) caregiver,
- primary care physician,
- geriatric nurse practitioner,
- social worker,
- rehabilitation specialist, as necessary,
- a specialist in a particular chronic care disease, as necessary.

Extended care pathways

Extended care pathways (ECP) are an important technique for integrating care management for persons with chronic conditions. As the NCCC defines it, an extended care pathway is

> a set of policies and procedures that providers use to address a specific disabling chronic condition over time and across various service settings. It is a standardized approach to the multidisciplinary care of an individual with a particular diagnosis.

Extended care pathways are designed to increase continuity of care between settings, and thereby improve both the quality and the cost-effectiveness of care. In today's fragmented healthcare system, where a person with a chronic illness can be sent from one care setting to another with no real continuity between providers, extended care pathways offer a means of increased provider communication and collaboration.

More specifically, extended care pathways delineate what will be done, at what particular points along a specified time scale, in order to achieve the desired outcome. An ECP represents a consensus of expectations for a setting and diagnosis. It is intended to be used as a tool for managing, monitoring, and evaluating care.

Extended care pathways are related to critical paths, an increasingly common tool used in acute care settings. Both critical and extended care paths indicate what important events are necessary for individuals to meet expected outcomes. The major difference between the two types of pathways is that extended care pathways are expected to apply to the entire course of a condition, whereas critical paths generally pertain to care received by an individual during one episode of care in one setting.

In June 1995, the NCCC published an 80-page report entitled *Conceptualizing, Implementing, and Evaluating Extended Care Pathways*. This report is available for $50.

Call the NCCC at (612) 858-8999 for more information.

Potential benefits of integrated care management

One can hardly overstate the importance of integrated care management in serving a chronically ill population. For a chronic care network, integrated care management is a means of providing rationale, humane, desired and effective care to clients. The benefits of integrated care management to a chronically ill person are evident. But what can a health care network hope to get out of an integrated care management approach?

Better care and the ability to define and implement better methods of care by condition or population group.

Lower costs due to fewer hospitalizations, fewer readmissions, fewer nursing home admissions, better use of home health and physician office visits, and fewer unnecessary emergency room visits.

Greater satisfaction among staff and clients. Effective integrated care management results in less turnover among staff, better staff morale, and more communication and sharing of new or improved clinical approaches across the organization. There is also a decrease in disenrollment by health plan members.

An improved ability to predict and plan for the needs of special populations. This ability comes from aggregating information at the population or condition level, tracking both costs and care outcomes, and identifying population group characteristics that allow the CCN to predict client health status and health services need. This is especially important as networks compete for managed care contracts and/or work directly with employers to provide a set of services over a given time period for a defined population.

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The National Chronic Care Consortium (NCCC) is a mission-driven organization of leading-edge health networks dedicated to transforming the delivery of chronic care services. The NCCC's mission is to serve as an operational laboratory for enabling innovative health networks to establish prototype systems for better serving persons with chronic conditions.

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