Care management continuum

The number of different models and approaches to care management has become confusing and even contradictory.  Some care management approaches are offered out of practices (e.g., nurse care managers), some are based in practices but spend significant time in patients’ homes and communities (e.g., health coaches), some are community based (e.g., community health workers), and some are even based at payers.  Yet there is no particular logic for which of these models is followed, which patients receive which service, or how they should coordinate and interact- rather than duplicate efforts.  More often, local funding decisions determine which service an individual will receive.

The attached map of [Care Management Continuum](http://psychologicalcenters.com/wp-content/uploads/2008/03/Care-Management-Continuum.docx), the patients they are ideally suited to serve, and how they relate to one another is a first effort to organize this continuum based on clinical rationales.

1. Evidence seems to indicate that the most effective care management services are based in practices and are offered by staff with ongoing relationships with patients.
	1. The most widely recognized care management models are care managers or nurse care managers based in primary care practices, often as a core element of the Patient-Centered Medical Home (PCMH). These staff typically focus on high need patients served by the practice, often with chronic diseases or other poorly managed medical needs, using registries or primary care provider referral to determine needs and goals.
	2. A similar model would be relevant for behavioral health practices, especially among community populations whose resources and capacity to make effective, consistent use of health care services is often compromised. There are fewer funding models for such positions than for PCMH-based care managers.
	3. Where patients are managed on an ongoing basis by both primary care and behavioral health practices, care management duties will be shared and need to be coordinated, if not integrated. In integrated practices offering sufficient behavioral health specialty services as well as primary care, one integrated team can be responsible for both sets of needs.
2. Mental health and substance use needs of primary care patients are often under-served by primary care based care management teams. Yet several models of coordinated care management and consultative care, behavioral health screening, evaluation, and referral, and services for the behavioral elements of medical care have all shown significant positive effects on health outcomes and health spending.
3. Though less common and less well studied, the dramatically increased mortality of people with serious mental illnesses from comorbid medical conditions has prompted widespread interest in medical management associated with behavioral health treatment settings. Co-located nurse practitioners have been used to evaluate and coordinate care for medical needs with primary care and other medical providers. Behavioral health care managers (often called case managers) can be trained and held responsible for coordination with medical care, and medical care managers can be co-located and offer coordinated care management with behavioral health care managers.
4. Some care management models focus on population management, not just focusing on services for the highest need patients. These programs offer preventive supports, health promotion services, population monitoring for high risk and general risk targets, and training and assistance for patients and families to improve self-care.
5. Patients with multiple providers or particularly complex care often need additional, more extensive or aggressive, or specialized care management services. High risk care coordination teams specialize in patients with identified risks. Such teams can be specialty services of on-site care management teams or staff, or can be specialized teams in specialty care settings or across affiliated practices.
6. Many patients and many potential care management targets with high impact on healthcare outcomes are poorly addressed by these varieties of practice-based or practice-focused services. For patients unable to access practice-based care management or otherwise not reached by site-based teams, community health teams and care managers (often called community health workers or peer support providers) can address needs that would otherwise be poorly managed. In particular, social determinants of health and mental health and substance use problems that are difficult to identify, diagnose, or manage outside their natural settings can be effectively addressed through home and community-based services. This include home-based medical and behavioral health care, often offered by VNA or home-based therapy services when funding allows.
7. Because of the costs, problematic outcomes, and failed care efforts of transitions, especially from high risk/high need settings, care management programs have been developed to focus on supporting effective transitions in care. Sometimes these are telephonic, based at payers attempting to reduce unnecessary admissions or readmissions to hospitals. Other times these are services offered by care managers already involved with patients when they are notified of admission or discharge from Emergency or inpatient care.
8. Finally, many payers in particular have identified pools of patients who are not successfully managed by any of these other care management resources, if even available. For patients whose healthcare utilization and spending indicate poorly managed needs, especially in the absence of successful engagement by other care management services, these payers may offer (or even require) involvement with intensive care management programs funded and managed by the payers themselves.

Although each of these approaches to care management offers distinct benefits to distinguishable pools of patients (including all of us in one pool or another), their overlapping and inadequately coordinated services are inefficient at best and conflicting at worst. Ideally, one complete continuum of funded care management services with discrete criteria for type and amount of service would enable closer coordination, more comprehensive but appropriately scaled intensity, and the most efficient use of care management resources to ensure the most effective and most efficient use of healthcare resources possible.