



Care Management, Case Management, and Utilization Review in a Managed Care Environment

An Introduction to Terms and Concepts

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The Technical Assistance Collaborative, Inc. is a not-for-profit organization providing consultation and technical assistance to national, state and local health, human service and special needs housing organizations. The Boston-based organization was created to help state and local public mental health agencies prepare for a changing health care environment. Much of our work has been on the design of state and local human service delivery systems which emphasize community support and consumer choice; and positioning organization to take advantage of changes in health care policy and financing, including opportunities in manages care.

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CARE MANAGEMENT, CASE MANAGEMENT, AND UTILIZATION REVIEW IN A MANAGED CARE ENVIRONMENT

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INTRODUCTION

In any managed system of behavioral health care,¹ certain functions must be performed to assure that services provided are planned, efficient, coordinated and likely to produce positive results for the individual receiving care. Additionally, in publicly funded managed care systems, the community and the payer have an interest in assuring that public dollars are stretched as far as possible and used well, and that the community as a whole benefits from the expenditure of those funds by increasing the productivity, safety and well-being of service recipients.²

For the last several years, various approaches to assuring these results have been tried through quality improvement mechanisms, audits and accountability studies, and specialized services targeted to clients³ with long term and persistent mental health needs or peer support approaches such as Alcoholics Anonymous sponsors. However, these approaches have been limited by being after the fact, or focused on only one aspect of the system at a time (i.e., individual client care, expenditure of funds, etc.). With the introduction of private sector managed care technologies to publicly funded systems, the "wisdom of approving services ahead of time; preventing different agencies from repeating key functions for a client such as evaluation, case management, or service planning; and assisting service recipients as well as providers to think about difficult treatment situations, has become apparent. Only with these technologies, can true value be achieved both for those receiving and purchasing care and for those asking for that care.

The question is: How does this facilitation of services toward a good and cost effective result occur? What are the various activities involved in those technologies, who does them, and how are they best structured in an organized system of care? To answer these and related questions requires an understanding of terms, a comparison of related concepts, and a look at examples of various ways to structure different functions within an integrated, organized behavioral health system of care.

¹ The term "behavioral health" is used in this paper to mean mental health and substance abuse systems and services.

² Communities and payers also benefit from the expenditure of public behavioral health funds in other ways, for example, by prevention and community education programs. However, these are not the subject of this paper.

³ The terms "service recipient," "client," and "consumer" are used interchangeably throughout this paper to mean an individual adult or child/adolescent or a family served or potentially served by a mental health or substance abuse system or provider.

USE OF TERMS

Managed care is a relatively new way to organize, fund and hold accountable behavioral health systems of care, especially in the public sector. Consequently, concepts and terms used to describe different functions are not consistent across states, managed care companies, or agencies. The concepts themselves are evolving as the field learns more about how to make use of commercial managed care technologies and adapt them to publicly funded settings. No single set of definitions are universally accepted for different terms and multiple terms are often used to mean the same thing.

For purposes of this paper, it is more important that concepts be clearly delineated and differences understood than that precise and "correct" definitions of "correct" terms be applied. It is also important that functions themselves be differentiated from the method "by which a system organizes and structures those functions within a service delivery system. The goal is to assist those individuals planning managed systems of care to avoid duplication of effort among the very functions whose purpose is to avoid duplication and unnecessary services, while assuring delivery of needed services to effect good client outcomes.

Certain terms need explanation simply to assist the reader in understanding this paper and general managed care terminology. For example:

Medical necessity is a term that came out of commercial and Medicaid managed care terminology, and is used to mean the general test a service must meet in order to be provided or paid for, that is, no service should be provided if, it is not "medically necessary," for that client. Many clients and advocates as well as providers of rehabilitation services object to this term as being too medically oriented, suggesting that social or rehabilitative services are just as necessary (if not more so) to a person's recovery as is "medical" intervention. This argument hinges on the definition of the word "medical" and the displeasure on many people's part with Medicaid's (and private insurance companies') unwillingness in certain circumstances to pay for supportive living, employment services, clubhouses, peer support and other critical needs the lack of " " which often keeps service recipients in more expensive and less helpful service settings. To address this concern, some jurisdictions have considered changing the term to *service necessity*, *clinical necessity* or *psychosocial* (or just *social*) *necessity*.

Most jurisdictions have, in the end, chosen to stick with the term *medical necessity* because of its long use in the health and Medicaid fields, and because that history gives some evidence that the word "medical" is not limited to literal medical interventions. Rather, the word "medical" has been used and interpreted in these contexts to include rehabilitative, assistive, and other services and supports for various Medicaid populations. This history gives it a better chance of being broadly rather than narrowly defined for behavioral health purposes, whereas use of a new term might be defined more narrowly than desired from the beginning and be open to interpretations by courts and regulators that would be more harmful than helpful.

Regardless of which term is used, and although each jurisdiction or system defines the term a little differently, generally, **medical necessity** has a similar meaning. Some states use a minimalist definition (e.g., California⁴) while some legal analysts advocate for an expanded definition (e.g., the Bazelon Center⁵). The issue is whether the term will be used technically to meet federal regulations while allowing professional judgment to interpret the definition in most clinical circumstances, or whether the definition will be used actively to guide the provision of professional services. Since **medical necessity** is part of the criteria upon which authorizations for care are given (see description of **Level of Care Criteria**, below), and since these decisions can be the subject of both provider and client appeals, the breadth or specificity of the definition is extremely important in managed systems of care. An example of a middle ground approach that provides a specific definition but which is not tied to specific contract terms (as suggested by the Bazelon Center) is the definition used recently in Connecticut.

In the Connecticut request for proposals for an administrative services organization to provide claims payment and utilization review for General Assistance clients, **medical necessity** is defined as follows:

A determination in the judgment of the Vendor that a particular mental health/substance abuse treatment service meets all of the following criteria:

- a) the service is appropriate for the symptoms, diagnosis and treatment of a particular disease or condition that is defined under DSM-IV, or its successor;
- b) the service is provided in accordance with generally accepted standards of mental health and substance abuse professional practice, including the American Society of Addiction Medicine and a bio-psychosocial approach to rehabilitation;
- c) the service is provided for the diagnosis or direct care and treatment of a disease or condition that is defined under DSM-IV, or its successor;
- d) the type, level and length of treatment services are needed to provide safe, adequate and appropriate care, and are deemed likely to improve the recipient's condition. Treatment geared toward simply maintaining the recipient's current level of functioning is only acceptable when, without such treatment, the individual would be likely to suffer a relapse which is serious enough to require the provision of services which are more intensive than those currently being received. Medical Necessity does not include "custodial care."

⁴ California defines *medical necessity* as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury."

⁵ See, "Defining Medically Necessary Services to Protect Plan Members;" *Protecting Consumer Rights in Public Systems – Managed Mental Health Care Policy*; The Judge David L. Bazelon Center for Mental Health Law; March, 1997.

Level of care (LOC) Criteria is a term used to denote those criteria used by all decision-makers in a system to determine what type of services a particular client needs. **LOC criteria** should not be confused with **eligibility criteria**. The latter are usually financial criteria [e.g. an individual's income is no more than 100% of the Federal Poverty Level (FPL)], membership in a group (e.g., the individual is an employee of a certain company or the individual is Medicaid eligible), and/or sometimes disability specific (e.g., the individual is an adult with serious and persistent mental illness). **Eligibility criteria** are used to determine whether an entity is responsible for payment for the individual's care, i.e., whether a person is eligible for services paid for by a particular fund source. **Eligibility criteria** have no use in determining what kind of services would best meet that individual's behavioral health needs at the point in time services are requested.

On the other hand, **LOC criteria** identify what symptoms, behavior/or functioning an individual must be exhibiting to warrant a particular service. Each service or service grouping offered by a system of care (e.g., acute inpatient, residential treatment, medical detoxification, ambulatory detoxification, in-home respite, intensive outpatient, brief therapy, etc.) should have **LOC criteria** associated with it. These **LOC criteria** are used by evaluators, providers, care managers, utilization reviewers and others to determine what service modalities (or levels) the individual with whom they are working needs and whether the individual continues to need that level of care after receiving that service or service grouping for a period of time. **LOC criteria** include clinical and behavioral indicators, as well as availability of alternative resources, sources of support for the client, willingness to accept certain services or settings, whether the service is likely to produce positive clinical (medical or rehabilitative) outcomes, etc.

If a service recipient is unhappy with the level of care to which is or she is assigned, or if a service is denied (that is, not authorized) and he/she wants to receive that service, the individual may appeal or grieve that decision in a managed care environment. Likewise, a provider who wishes to or has provided a service for a client for which an authorization is denied by the manager of care (the payer), the provider may appeal that decision through a separate process. In either case, the decision-maker's adherence to the **LOC criteria** while making the decision that resulted in the denial will be the primary subject of that appeal. Because of the importance of **LOC criteria** in publicly funded managed care systems of care, the purchaser (state or local government) will often establish the **LOC criteria** that the payer/managed care organization (MCO) or provider network must use. In other cases, the purchaser establishes guidelines about **LOC criteria**, and allows the payer to establish the actual **LOC criteria**, often with the approval of the purchaser.

The time period for review of care established by **LOC criteria** may be determined by the clinician and the client together or by a predetermined time period associated with that level of care, whichever is sooner. The time period for review does not mean the client can no longer receive that service (or level of care). But it does trigger a formal, documented review to determine whether the individual's functioning, symptoms and/or behavior have changed or whether they have not changed, and therefore, in either case, a different level of care (lower or higher) should be considered to help the individual meet his/her treatment or service goals.

Expected outcomes or results is an important part of *LOC criteria*. No one should continue to receive the same service over and over again with no clear results. No results (after a reasonable period of time) suggests a need to consider other approaches. However, stability of condition can be a positive result for some clients. If it can be shown that the stability is the result of the service provided (e.g., medication, or a job) and that withdrawal of that service will result in destabilization or worsening of the client's symptoms, functioning or behavior, then upon review, that level of care may legitimately be continued.⁶

Care must be taken not to mistake stability with the best a client can expect or achieve. For example, just because a client is stabilized in a hospital setting and has de-compensated or returned to substance abusing behavior when released from the hospital in the past, does not mean the client should continue to be in an inpatient level of care. Rather, it may mean a different level of care or different approach needs to be tried upon discharge to help prevent future relapses. A recovery model suggests that each individual, with help, support, and some type of therapeutic assistance to break through the denial of addiction, will progress in his/her ability to manage and overcome his/her own symptoms and enjoy an increasingly productive, self-sufficient and satisfying life. While a few clients may need to rely on a particular level of service for life, managed care and a recovery model do not assume that will occur. The use of *LOC criteria* provides opportunities and methods to review service approaches and benefits received at regular intervals.

It should be noted that *LOC criteria* may be based as much on service philosophy or goals of the system rather than exactly what the client wants and needs. For example, a client may need something for which the system, as a matter of public policy at legislative, executive and managed care system levels is not willing to pay. The system's philosophy may be basic care and safety or optimum movement of the member to the highest level of functioning possible within the limits of the benefit package and the available funding. This service philosophy allows the community as a whole to design the goals of the system it funds. However, an individual client may want and need something beyond this and may appeal or grieve when he/she does not receive it. A service philosophy of recovery and optimal client quality of life and productive is the best approach to managed systems of care, but few legislators and/or purchasers (states) as well as few taxpayers are willing to fund this level of care and this amount of flexibility in service design and benefit packages.

Level of care criteria should not be confused with *protocols* or *practice guidelines*.

⁶ Use of *LOC criteria* can be tricky when a person is involuntarily committed pursuant to state law. Frequently, the state law criteria for involuntary hospitalization (or outpatient commitment, where that is allowed) are not consistent with the *LOC criteria* utilized by a service delivery system. *LOC criteria* are based on the best service approach, the allowed benefit package for that particular client, and whether any other alternatives are available or could be tried for this client. Involuntary commitment criteria are usually based first on diagnosis and clinical indicators and then on public safety indicators, i.e., whether the individual has been dangerous recently to self or others or is unable to care for him/herself. Managed care systems will or will not authorize payment for involuntary treatment regardless of whether *LOC criteria* are met, depending on the contractual arrangements or other agreements with the purchaser (usually a state or local government.)

Protocols are written actions the system requires be taken by a system decision maker and/or clinician to handle, treat or deal with identified situations. They are a way the system assures that there is a proper response to a given situation. For example, a written **protocol** might define the steps to be taken in a life-threatening crisis to alert authorities, the on-duty physician and/or the involved case manager as well as the clinical actions to take to prevent harm. Or a system might have a **protocol** describing when and how to request a new experimental medication for a client with presenting symptomatology and a clinical history suggesting the need for such an approach, along with the delineation of informed consent disclosures and special clinical monitoring requirements for anyone prescribed such medication.

A protocol can also be used to assure good diagnostic/treatment fit. For example, a **protocol** might describe a certain set of symptoms and presenting history and behaviors that would require medically observed detoxification before beginning anti-depression or anti-anxiety medications. **Protocols** might be described as service oriented policies and procedures that are used to prevent harm, reduce risk or liability, and assure that professional or clinical-judgment is not exercised in a manner that is so individual as to be irrational and unlikely to produce a good result. **Protocols** are best used when treatment or service approaches are risky or difficult and need to be followed precisely to be safe or effective and/or when professional knowledge about how to treat or intervene with a particular presenting situation is so clear that to do otherwise would be highly unlikely to be successful.

Practice guidelines, too, are based on knowledge about what is likely to be successful. They provide guidance to the field about the best way to provide care and treatment, given current state of knowledge. They do not, standing alone, constitute the criteria for payment authorizations or policies and procedures for handling situations presented in clinical settings. They do, however, inform those criteria and policies. **Practice guidelines** are usually produced by professional groups such as the American Psychiatric Association (APA), or the National Association of Case Management (NACM) or by a professional group or leader within a system of care (e.g., physicians, Medical Director, Clinical Director, Case Managers or Case Management Supervisor) to guide clinical⁷ decision-making. Clinicians may be asked to explain why they did not follow a **practice guideline**, that is, it is a guideline of a profession against which individual actions may be judged, but the violation of which may be adequately explained in certain circumstances by good clinically appropriate judgment to the contrary. On the other hand, clinicians may be disciplined or even sued for not following **protocols**. **Protocols** have the force of policy, regulation or industry standard for which there is not likely to be a justifiable variation except through proper channels that results in a change to the adopted protocol.

Level of care (LOC) criteria should also be based on professional industry knowledge about what is likely to work best, but **LOC criteria** are used to determine what service the system payer will pay for, for what kind of client, for how long, before requiring further justification that continuing to provide that service is likely to result in more client

⁷ The term “clinical” is used in this paper to mean any decision or interaction having to do with individual client care as opposed to system or management decisions.

improvement or a better client outcome. **LOC criteria** should not be contrary to professional industry standards, but are based in part on the particular services available in the defined benefit package for the defined populations as well as on good clinical practice. **LOC criteria** are used to make decisions about authorization of payment for a service, and whether there might be alternative equally effective treatments or services that should be tried first, not on whether the service should be provided or how that service or treatment should be administered.

An example of the differences in these terms might be the fact that certain clients who have a certain income level and/or diagnoses or disability status would be **eligible** for medication and medication monitoring if it is determined to be **medically necessary**. In order to determine the **medical necessity** for medication monitoring for an individual client once he/she is determined to be **eligible** for the service, **LOC criteria** are used to examine current diagnosis, current symptoms, and history of medication use. Such use of **LOC criteria** would likely result in a denial of payment for medication or medication monitoring for an **eligible** client who has been symptom free without medications for two years without other indications suggesting a current need for medication or likelihood of medication ameliorating or preventing illness or symptoms.

If the client is on medication and receiving medication monitoring and is experiencing significant side effects making compliance difficult, **practice guidelines** might suggest trial on other medications or additional medications to control side effects. **Practice guidelines** might also suggest regular time intervals for evaluating the client for tardive dyskinesia or other debilitating side effects. **Practice guidelines**, based on what the industry currently knows, might also suggest to the clinician that he/she ought to seek authorization (if required) or prescribe a newer medication such as Clozaril or Risperadol.

If such medications are in fact prescribed, **protocols** may require that the clinician discuss required disclosures with the client and seek specific informed consent before administering the medication. **Protocols** also will require that certain blood or other lab tests are performed while the client is on Clozaril to prevent the development of life or health threatening physical conditions. **Practice guidelines, protocols** and **LOC criteria** may all require the physician to review the use of such medication periodically and justify or reconsider other medications and/or seek additional authorization to continue the medication, given the benefits or lack thereof experienced by the client from the medication. One of these terms governs clinical guidance, one governs rules of practice in a certain provider or system, and the latter governs the likelihood that the practice will be paid for by the payer. (Clozaril is expensive and potential hazardous to health. Continuing to use it if there is no benefit to the client would not likely be supported by **practice guidelines, protocols** or **LOC criteria**.)

These terms are frequently used interchangeably, or differently than described above. Again, the important point is to understand the different concepts used in managed care, not the particular labels anyone system uses to designate those concepts.

CARE MANAGEMENT. CARE COORDINATION. UTILIZATION MANAGEMENT, UTILIZATION REVIEW, RESOURCE MANAGEMENT, CASE MANAGEMENT, AND OTHER CONFUSING TERMS

These terms and the confusing and inconsistent ways in which they are used are the crux of this paper. It is important to reiterate here that the precise term used is less important than understanding or distinguishing between the concepts. It is also important to remember that each concept encompasses a set of functions or activities. How these activities are structured or arranged and who does them can vary significantly from one system to another or even from one population group to another within the same system. For example, *care management* activities can be done by case managers for some clients or by clinical supervisors for other clients (or in other systems). It can even be done by primary care physicians in some systems for some clients. *Case management* can be done by therapists for some clients, by designated individuals for others, and by teams for yet others.

Some systems have *care managers* who do *utilization review*. Others have *utilization reviewers* doing part of the *care management* functions. Some systems call *care managers, care coordinators*,⁸ and some call *care management, utilization management*.

Confused yet?! Let's try to clear the waters, at least for purposes of this paper, so that concepts can be distinct regardless of what term is used and rational decisions about structure can be made.

Utilization Management (UM) is a term that will be used here to mean a system's overall strategy for managing service utilization by individual clients and by the system as a whole. *UM* is accomplished through a combination of care management (care coordination), case management, resource management, and utilization review activities as well as by using MIS and financial data to determine trends and service use patterns. *UM* is a combination of management and clinical decision-making to make sure services used are appropriate, making a difference and producing the best value possible.⁹ *UM* overall is often done though a committee composed of system, clinical, financial and management leaders who review and monitor aggregate service utilization data and trends, then make recommendations about service system changes or changes in protocols, practice guidelines or *LOC criteria* to help keep the system's overall use of higher cost and more intensive services down and the use of more or equally effective lower cost alternatives up. The focus of *UM* is system wide, with an overall goal of keeping costs down and services appropriately distributed (i.e., making sure 5% of the clients do not inappropriately use 90% of the resources thereby leaving only 10% for the vast majority of the population for whom the system is responsible).

⁸ Note: Some systems have customer service representatives whose interventions on behalf of clients who request help look a lot like some aspects of *care management* and some aspects of *case management*. Consumer advocates and ombudspersons also do some activities that are similar. Straightening out these confusions is beyond the scope of this paper.

⁹ "Value" is defined here as the most number of clients served with the best possible outcomes for the least amount of money.

Care management and *care coordination* are terms used interchangeably in this paper. *Care coordination* is a set of activities by which a system of care assures that every person served by the system has a single approved care or service plan that is coordinated, not duplicative and within prescribed parameters designed to assure cost effective and good outcomes. Its goal is both managing and stretching limited resources, as well as assuring the best quality care possible to achieve the client's service goals. *Care coordination* is often done intermittently, when the individual first comes into the system of care and at critical treatment junctures, such as client movement from one level of care to another. *Care coordination* interfaces with both case managers and utilization reviewers to assure good communications, problem resolution, quality service provision, and ease of transition. *Care coordination* can also provide consultation to clinicians (including case managers) both within and outside the provider network regarding alternatives, creative approaches to care, etc. Providing logistical coordination of services for clinicians adds to consistency of practice and standardization of expectations which can also be beneficial to both the system and its service recipients. *Care coordination* is often not provided face-to-face with the client, rather contact is frequently with providers or clinicians and may be done by telephone as often as face-to-face.

Sometimes, *care coordinators* approve pre-authorized service packages for persons as they enter a system of care. For example, for persons meeting certain level of care criteria, a provider may be authorized to serve that individual within a package of services that includes limits on the number of sessions, limits on the amount of overall dollars spent, or both. When that service package is completed or used up, the provider may request further services for the client based on documentation of continuing need and an expectation of continuing benefit from the provision of further services. *Care coordination* plays a role in authorizing both the initial service package based on a review or direct evaluation of the individual to assure that service package (as opposed to - less or more services) will meet the individual's needs, as well as a role in authorizing continuing or more services once the initial package has been exhausted. In some systems, the initial service package utilization is determined only by providers, with *care coordination* coming into play when the provider believes the individual needs more or different services, and when case file reviews are done by the system to check the documentation and accuracy of provider and other level of care decisions.

Care coordination and *utilization review (UR)* share some aspects and part of the activities of both may be done by staff called either *care coordinators* or *utilization reviewers*. *UR* is used here to mean a specific decision made at a particular point in time when either the client or a clinician/caregiver requests a certain service or service package for a client presenting specific symptoms or behaviors. The *UR* process uses *LOC criteria* and sometimes a certificate of need (CON) to document that the client's situation at that point in time meets the criteria for use of the specific service or package requested. Typically, *UR* and the ultimate decision whether the payer will authorize payment for the requested service(s) is done by persons other than the treating clinician or responsible service provider. *UR* is usually required for those services that are particularly expensive or particularly intrusive, or services that a system wants to or is required to use less of or find alternatives for, e.g., inpatient, hospital based detoxification, partial hospitalization, non-emergency transportation, out-of-home residential care, etc.). *UR* may occur at the point of initial service (*pre-authorization* of

an predetermined service package may be done by providers or *care coordinators* if a client is evaluated and found to need a low or brief level of care). *UR* may also occur at the point a particular high end/high cost service is requested (*prior authorization* of a particular service for a particular amount of time), and during the delivery of the authorized service to determine if the service continues to be needed and for how long (*concurrent review*). *UR* also occurs after the authorized service has ended for a particular client by the conduct of chart reviews to determine whether the record documents justification for the service (*retrospective review*). The use of aggregate information collected from these reviews is a key part of *utilization management*, and is also used for quality management or continuous quality improvement efforts of the system as a whole.

Different aspects of *utilization review (UR)* can be organized and structured such that different players in the system can perform different reviews. Whoever does *UR*, each decision must be made using consistent *level of care criteria*, so that clients, clinicians, provider agencies, and *utilization reviewers* are able to anticipate and understand the decisions that are made. It is also critical to understand that *UR* decisions (especially prior authorization and concurrent review) are decisions to deny a person care. Rather, these decisions indicate that the individual's current situation, as described to the reviewer, does not currently meet the criteria for need for the particular requested service, and therefore, the payer will not authorize payment for that service. The caregiver is free to provide the service anyway with other resources, or the caregiver may be required to seek alternatives that are more effective for which the client's current described symptoms and behavior do meet the criteria. Additionally, the caregiver may be requested to provide further information to document the need for the service before authorization is given. When a *UR* decision to "deny" is given, it becomes incumbent on *case managers* or other clinicians to find other ways to serve the client for which the system is able to pay. Sometimes, *utilization reviewers* or *care coordinators* play a role in suggesting or creating alternatives for such clients.

Resource management is a term that denotes the part of *utilization management* that assures that a system's resources are fully used and are expanded or contracted as needed to serve the population(s) for which the system is responsible. *Resource management* includes keeping track of service capacity and availability. Openings within the provider network of beds, treatment "slots," case management or therapy sessions, etc. are monitored and centrally available for use by system access points, information and referral systems, and the emergency/crisis system. *Care coordinators, case managers, utilization reviewers*, and providers all use this information to make sure people who need services of a certain type are not "stuck" in one type of service simply because they are waiting for a more appropriate type of service to become available. *Resource management* may include having the ability centrally to schedule appointments with any appropriate provider regardless of where the individual first contacts the system. Those responsible for *resource management* also have a responsibility to let service developers know that more or less of a particular kind of service is needed in the system, based on use and demand. Sometimes, *resource management* is done by *utilization reviewers*; sometimes it is done by a completely different section of a managed care organization or system; and sometimes it is merely an MIS function that tracks service availability and scheduling and is used electronically by various players in the system of care.

Case management is a concept that has been in behavioral health systems for decades [especially for adults with severe and persistent mental illness (SPMI) and more recently for children with serious emotional disturbances (SED) and has evolved over time as more research about models and effectiveness has been done]. **Case management** is a clinical service focused on those individuals who are determined to need assistance with coordination of services; daily living skills; finding and maintaining housing, jobs and friends; and in some cases, a single long-term relationship with a professional caregiver or helper. **Case management** is provided continuously, even if there is no immediate need for services, so long as the individual is determined to need the assistance a **case manager** can provide. The goal of **case management** is the long-term recovery of the individual and increasing the ability of the individual to cope and function independently, including managing his/her own symptoms or addictions, and finding and maintaining his/her services and community living requirements.

Case managers interface with other providers and with family and other natural supports in the individual's environment on behalf of the individual served. They attempt to coordinate and ensure everyone is working in concert with the individual to meet his/her needs and goals. However, the primary contact and relationship is with the individual him/herself, regardless of the treatment or living setting, and regardless of whether the individual is doing well or needing more intensive services for a period of time. A system of care should ensure that any service recipient determined to need this service or level of care has only one **case manager**, and that the **case manager** is not connected to or limited by the boundaries of a particular service setting. A **case manager** may perform some activities associated with **care coordination** for those individuals who are determined to need **case management**. However, **case management's** primary goal is service provision for an individual, not management of the system or its resources (although the latter may be the result of good individual **case management** for persons with high needs, whether mentally ill, addicted, or both).

There are different kinds or models of **case management** described in the literature about this service. Traditionally, the least intensive approach (sometimes called *broker model* or *service coordination*) is a service in which the **case manager** uses primarily the telephone and other in-office techniques to refer and connect the individual to needed services both within and without the behavioral health system. The functions are sometimes similar to functions performed by **care coordination**, however the latter is concerned more with managing the efficiency and effectiveness of a client's care including services and costs, while the *service coordination* approach to **case management** is primarily concerned with facilitating referrals and scheduling of services.

Another more intensive (and usually more of a dedicated personnel) approach to **case management** focuses on the *recovery* of the individual in service (and is similar to what some call the *rehabilitation model*). In this approach, the **case manager** often has lower case loads and assists the individuals whose symptoms are fairly stable or sober/straight and well on the path to recovery, to gain or learn social and rehabilitative skills to help them live successfully in the community. Activities might include assistance with housing, benefits, jobs, education, socialization, and development of natural supports, etc. This assistance is provided both in-office and *in vivo*, that is wherever the individual needs help. It might include calling or negotiating with landlords, assistance with filling out forms or applications, job seeking and interviewing, support while on the job,

arranging for and going with the individual to social events, arranging for transportation or driving the individual to appointments, etc. The philosophy of this approach is assistive in nature and uses the strengths of the consumer, starts with what the consumer has going in his/her life, and focuses on the consumer's recovery and ability to manage his/her own life, symptoms and services as the most important outcome for the consumer.

A third approach to *case management* combines treatment and support services as well as linkages to needed services by an individual or team of professionals (sometimes called an *assertive community treatment [ACT] team*). In this approach, a *case manager* (usually as part of an *ACT* team of case managers, supervisors, a nurse and physician) provides intensive *in vivo* services for a small number of individuals who may not be stable, who have high needs for support and assistance, and who would be highly likely to be in an institutional or inpatient setting if not for the intensive frequent intervention. This approach provides medication monitoring, crisis intervention, in-home respite, one-to-one supports, and even facilitates involuntary treatment upon occasion, to assist the individual to remain in the community as much as possible. All the activities and the philosophy of the *recovery* approach are included but more often, more basic, and more intensely until the individual is able to do more for him/herself.

Additionally, *ACT* teams may provide a fair number of services directly while facilitating, arranging, and taking clients to these services. *ACT* teams also provide some social activities and skills training while assisting the client to negotiate and learn how to live in the natural community. Persons receiving this type of *case management* are likely to be high users of expensive or restrictive services, to have repeatedly been unable to manage symptoms or addictions alone, and to have repeated interactions with criminal justice and an inpatient level of care and/or been homeless.¹⁰

While parts of each of these approaches may be provided in a number of ways for a number of different types of individuals, managed systems of care are beginning to use these concepts to think about different levels of intensity of *case management* that individuals might receive at different parts of their recovery process, depending on their needs and progression. For example, some persons may need case management during acute periods of illness, for short periods of time, while others may need assistance from a case manager or team on an on-going basis beyond periods of acute distress. Transitions between models and/or levels of case management must be done carefully to prevent disruption in care and to maximize recovery. An excellent description of all these concepts and related issues can be found in the National Association of Case Management's recently released "Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness," written by Martha Hodge, M.S. and Linda Giesler, M.P.A. While this document is written primarily about services for SPMI adults, the concepts and ideas can easily be translated for those individuals with addictions and for children and adolescents.

¹⁰ Some experts argue that ACT teams are only effective for the consumers they are designed to serve if they are organized and operated with high fidelity to the original model. See, McGrew, J.H., Bond, G.R., Dietzen, L. and Salyers, M.; "Measuring the Fidelity of implementation of a Mental Health Program Model;" *Journal of Consulting and Clinical Psychology*; Volume 62; pp. 670-678.

CONCEPTS COMPARED

All the terms and concepts discussed above can be very confusing. Three key concepts – *care coordination*, *utilization review*, and *case management* – are compared below in table form to assist in understanding distinctions and relationships. Following this comparison, examples of different ways to structure these three different concepts in a managed system of care are described.

| | Care Coordination | Utilization Review | Case Management |
|---------------------|---|--|--|
| Definition | Individual client care decisions and facilitation at critical treatment junctures to assure clients’ care is coordinated, received when they need it, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Sometimes called “care management.” | Individual client care decisions about the need for a particular (usually high intensity or high cost) service at a particular point in time, and hence about the responsible payer’s agreement to pay for the service (authorization to a provider to proceed with service and expect payment from the payer). | A clinical service in which individual client care decisions are made throughout a client’s relationship with both formal and informal caregiving systems to assure the client’s desires are known, his/her goals are achieved, needed services are provided, and he/she is better able to live, work, play and participate in the life of his/her chosen community. |
| Who Receives | All Clients | Any individual client for whom a high or costly level of service is recommended at a particular point in time; and those clients whose use of services continues to be frequent, high or costly. (Often, these services are invasive and usually restrictive for the individual member. Therefore, this review assists the client as well as the system. | Those clients who have been determined to need assistance from an individual or team of professional caregivers to access needed services; exercise rights; obtain and keep housing, jobs and friends; love in the community without resort to extensive use of more costly or restrictive services; and prevent harm to self or others. |
| Who Provides | Clinically trained professionals with position, authority and skills necessary to determine | Clinically trained professionals; usually RN, MA, PhD, MSW, etc.; and in the case of denials of payment | Trained professionals and paraprofessionals with core competencies in symptomatology, use and side effects of |

| | Care Coordination | Utilization Review | Case Management |
|-------------------|--|--|--|
| | diagnostic/treatment fit, approve treatment/service plans, recognize the need for and link clients to higher levels of care quickly and efficiently, facilitate disagreements between providers or clinicians, and play a consultative role with providers, clinicians, case managers, and utilization reviewers. | authorization, physicians. | relevant medications, treatment/service planning in a multi-disciplinary approach, clients rights, teaching living skills, use of community resources, crisis intervention and management, therapeutic confrontation and support, advocacy, listening and engaging clients, cultural competencies. |
| Activities | <ul style="list-style-type: none"> • Developing or approving a single care plan for individual clients • Problem solving difficult situations for clients or providers • Consulting with providers regarding difficult or unusual care situations • Assigning primary care responsibilities • Coordinating client transitions from one service to another • Customer service interventions • Assuring clients are given more, less or different services (titrating) as needs increase, lessen or change • Interfacing with utilization reviewers and case managers • Authorizing payment for a set | <ul style="list-style-type: none"> • Approving (authorizing) or denying payment for services at a particular point in time based on information available and provided at that time • Linking to case managers or other caregivers when authorization is denied or when an alternative service would prevent the need for the higher level (or cost) service • Developing and disseminating aggregate reports showing uses (and costs) of services by client type and other characteristics along with trends • Recommending system, service or provider changes based on utilization data and reports | <ul style="list-style-type: none"> • With the consumer, designing an individual service or care plan to meet the individuals' needs • Service referral, linkage, "brokering" • Skills training • Communicating with other caregivers • Listening to clients, families and other persons significant to the client's life • Advocating • Building an engaging and therapeutic relationship with clients • Obtaining or assisting with benefits access • Scheduling appointments for clients • Coordinating all of a client's treating |

| | Care Coordination | Utilization Review | Case Management |
|--|--|--|--|
| | <p>amount or cost of a predetermined benefit package</p> <ul style="list-style-type: none"> • Providing leadership on development and use of communication protocols and pre-authorized service packages | <ul style="list-style-type: none"> • Maintaining information regarding service availability • Assuring maximum system use of available low end services and minimum use of high end services, based on needs of the system's clients • Providing leadership of Level of Care (LOC) criteria development/use | <p>professionals to assure a single consistent service/care plan</p> <ul style="list-style-type: none"> • Crisis planning and intervention • Assisting client with building and using informal (natural) support networks • Helping client articulate and achieve personal goals, including but not limited to housing and employment. • Informal client and family complaint resolution • Driving, accompanying and socializing with a client to achieve life skill goals. |
| Instrument Used to Make Decisions | <ul style="list-style-type: none"> • <i>Protocols</i> • Pre-authorized service packages • Clinical judgment | <ul style="list-style-type: none"> • <i>Level of Care criteria</i> • Pre-authorized service packages • Certificate (or documentation) of Need from requesting party • Trend and data analysis (for system recommendations) | <ul style="list-style-type: none"> • Service or <i>practice guidelines</i> • Service plan • Guidance from physicians or team • Clinical judgment |
| When | <ul style="list-style-type: none"> • At critical treatment junctures • Initial entry into services (pre-authorized service package) • Movement from a higher to a lower (discharge) or a lower to a higher | <ul style="list-style-type: none"> • When a predetermined high level (cost) service is recommended for a particular client (prior authorization) • While a client is in a high level or high cost service to determine need for continuing | <ul style="list-style-type: none"> • Throughout a client's care, whenever assistance is needed, <u>and</u> at regular predetermined intervals (e.g., daily, weekly, monthly, every 90 days, etc., based on the client's |

| | Care Coordination | Utilization Review | Case Management |
|--|--|--|--|
| | <p>(admission) level of care, e.g., outpatient to residential or to inpatient, and vice versa</p> <ul style="list-style-type: none"> • Multiple providers are involved in a client's care • Client, family or providers disagree • Care planning becomes difficult or complicated | <p>care at that level and/or to suggest alternatives</p> <p>(concurrent review)</p> <ul style="list-style-type: none"> • After a client has received a service (or service package) to determine whether the client's condition justified provision of that service <p>(retrospective review)</p> <ul style="list-style-type: none"> • As aggregate data is analyzed on a periodic basis (monthly, quarterly, annually) to identify necessary system adjustments | <p>treatment/service plan and on practice or service guidelines))</p> <ul style="list-style-type: none"> • During a time of crisis for the client or family • Whenever a client's condition requires use of other system's services (e.g., medical, corrections, courts, etc.) |

EXAMPLES OF MODELS

There are many different ways that these different concepts can be put together to form a system of managed care. In some states, the purchaser (state) has determined that a statewide administrative services organization (ASO) will perform prior authorization and concurrent review, two *utilization review* activities for certain high end services for specified populations. *Care management* and *case management* are done by local authorities, providers, or provider networks. In other states, the purchaser (state) has procured a managed care organization (MCO) or provider network(s) to be the payer and manage the system of care. In these instances, the MCO or network will propose or design the system according to what it believes will work best and according to specifications in the bid document from and/or contract with the purchaser. In these instances, different aspects of the system can be done in many different ways, but the concepts are still all there.

In other states, the purchaser (state) requests the local mental health/substance abuse or behavioral health authority to apply to be the manager of care/payer if it is interested in such a role. In these states, the local authority (sometimes a county or group of counties; sometimes a non-profit organization or statutorily created board) either elects to do the management of care itself or with an MCO or ASO partner. Also, in these states, the organization of the system, who does which of the activities described above, in what mix and match of designs, is open to variation, depending on the local history, capacity and current operations.

Regardless of the system management or structure, there are different ways of arranging these functions and activities, and different terms for the different concepts. However, the concepts remain the same, even if mixed together in one professional or if called by terms other than the ones used in this paper.

Below are examples of four models for organizing some of the functions described above. Different models can be used for different populations. However, to the extent possible a single system that works for all populations served will be most efficient and less confusing for consumers/clients, providers, and other stakeholders. These models are not the only ones possible, but do provide ideas for approaches to organize the described functions in a variety of ways.

I. Care Coordination/Utilization Review Combination (Care/UR Combo) Model

- Care coordinator does both care coordination and utilization review activities.
- Case manager is a separate person and is only available for those clients who are determined to need this type or level of service.

II. Designated Care Coordinator Model

- All clients have a designated care coordinator, either within a provider or in an organization separate from service providers.
- Those clients who need it have a designated case manager separate from the care coordinator.

- Utilization review is done by separate individuals and/or is in a separate organization.

III. Therapist Case Manager Model

- Primary therapist or caregiver also performs case management activities.
- Supervisors perform care coordination activities.
- Separate persons and/or organization perform utilization review activities.

IV. Case Management/Care Coordination Combination (Case/Care Combo) Model

- Case Managers perform both case management and care coordination activities for those clients determined to need case management.
- Care coordinators are assigned for those clients who do not need case management.
- Utilization review activities are done by separate persons and/or separate organization.