

INTEGRATED CASE MANAGEMENT'S CONTRIBUTIONS TO **WHOLE-PERSON CARE**

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“**T**he most expensive and challenging populations found in the current healthcare system will remain underserved until there is a **unified effort** rather than small incremental steps to improve care for the nation’s high needs patients.”

—National Academy of Medicine

Care provided to individuals with complex health needs is often the most expensive, inefficient, and poorly coordinated across medical, behavioral, and social providers (Humowiecki, 2018). To promote health and wellness, a comprehensive approach to prevention is required. The Whole Person Care model is one such approach. Whole Person Care (WPC) goes beyond biopsychosocial care to focus more on the relationship

between patient and provider, not on the illness, condition, or disease (Thomas, 2018). WPC improves prevention efforts by addressing the factors that adversely affect an individual’s ability to be healthy. This translates to focusing on “health” and not “sickness.”

WPC is the next generation of population health management but will require additional efforts (Swift, 2020). Strong



organizational leadership and local stakeholder partnerships are needed to locate and provide services as are necessary for the most at risk and vulnerable (Swift, 2020). Mental health, social services, and wellness activities need to be aligned with medical care. To create a whole person framework, the characteristics of the targeted population need to be determined: what social determinants are present, income status, social supports, who utilizes and who does not utilize health services. All require analysis to determine what care management efforts and interventions will be of benefit.

Individuals with multimorbid conditions pose a challenge in the coordination of care. Care from multiple providers is standard, and coordination of this care from various sites often falls to the primary care provider (PCP). With shrinking numbers of PCPs and the growing number of individuals with multimorbid conditions, PCPs struggle to manage (Humowiecki, 2018). More practices are incorporating case management to assist with care coordination. Still, for those practices too small to hire case management staff, payer case managers can help with these activities. Multidisciplinary primary care practices contribute more to care coordination than solo practices (Kaufman, 2017).

WPC does not exclude any disease, condition, or circumstance. When executing a WPC model, one primary care provider addresses all needs that challenge an individual. The integration of medical and behavioral health is of itself a significant barrier. Healthcare professionals must be open to managing all the needs of a patient. Patients prefer the ability to receive most care and services in one location by trusted professionals. That doesn't mean specialists are no longer needed or accessed; instead, these are ancillary services coordinated by the PCP. At present, healthcare professionals remain challenged by a lack of complete integration of data, agendas, and health goals (Stumm, 2019). Most organizations agree that the problems facing individuals with complexity are that care is not sufficiently person-centered. Social determinants of health are not adequately addressed, data is scattered over multiple systems, and the current payment systems still reward volume over outcomes (Kaufman, 2017).

The many challenges of complexity have been outlined here, and while there is no one solution, case managers or integrated case managers are part of the solution. Case managers trained in an integrated approach are experienced but have participated in additional training to gain skills that improve care coordination for the most complex and vulnerable population. Long before whole-person care was identified as a preferred model, CMSA provided education and training to adopt an integrated approach. CMSA's Integrated Case Management program supports the WPC model and has been available since 2006. Case managers learn to engage and sustain trusted patient relationships as the primary contact managing all of their conditions, improve communication, advance assessment skills by learning to have a conversation instead of an interrogation. They understand the importance of removing bias and judgment, and accepting who the patient is: a unique individual with a unique story. Every individual with diabetes cannot be treated identically. Evidence-based and best practices for diabetes management do not mean every patient will respond favorably or as expected to the same treatment plan. When complexity is present, the causes can be much more than disease burden or symptomatology. Social determinants, under-treated, or untreated behavioral conditions are the most common contributors to poor health. Case managers trained in an integrated approach learn to longitudinally assess risk in the four domains of health: biological, psychological, social, and health system. Examining risk in each part, independent of the other realms, results in a more comprehensive assessment of where the patient's most significant risk lies. Then all risk areas are reviewed for their dependence on other areas of risk, which results in the ability to prioritize risk and develop a targeted plan of care.

The risk assessment and resulting plan of care focus on what is causing risk and poor health, the patient's experiences, and concerns, not just the disease or condition. The focus on "the what" and "the how" drive the value of relationships; relationships result in trust, trust results in collaboration, and collaboration leads

to confidence, which sparks patient independence and self-management.

"I diagnosed abdominal pain when the real problem was hunger; I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients' lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether."

—Laura Gottlieb, MD

To learn more about Integrated Case Management, visit www.cmsa.org. ■

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