Standards of Practice for Case Management

Revised 2022

CMSA STANDARDS OF PRACTICE FOR CASE MANAGEMENT TABLE OF CONTENTS

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Please access the electronic version of the CMSA Standards of Practice for Case Management at https://www.cmsa.org for available addendums.

Case Management Society of America
Standards of Practice for Case Management
Revised 2022

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Foreword

It is a pleasure and honor to write the foreword to the ***5th edition of the CMSA Standards of Practice for Case Management***. So much has changed, and yet so much remains firmly in place since I co-chaired and wrote the foreword for the 2nd edition of the Standards in 2002. It is important to recognize and celebrate the enduring commitments embedded in the 2022 Standards, including client-centered care, advocacy, professional practice and much more. Yet, Standards of Practice are not immutable – nor should we expect or want them to be. Critical changes cited in the introduction to this 5th edition, such as a global pandemic and the uncovering of unacceptable health disparities and inequities, have and will continue to influence case management practice in profound ways for decades to come.

Standards of Practice play a critical role for all professionals. The CMSA Standards of Practice for Case Management serve as a compass for all who practice case management. They stand as a blueprint for excellence in practice. I encourage you to refer to them often for inspiration about the values and philosophy guiding case management and the expectations for excellence and professionalism.

This 5th edition also is an urgent call to all case managers to practice at top of scope. The goals of case management cannot and will not be accomplished in half measure. Finding a meaningful balance in the integration of enduring and evolving practice standards will, no doubt, be challenging. Forming strong and trusting relationships with high-risk and vulnerable clients is not always easy and now, so much more complicated by constraints introduced during the pandemic and by demands for greater use of distance technologies. Systematic evaluation of case management practice remains critical. Fortunately, there are growing opportunities to influence the design and development of new measures that capture core processes and outcomes more fully and efficiently in a growing digital environment.

A key message in this 2022 update is that case management can and will continue to respond to the needs of clients and our healthcare system. Case Management practice will keep what is central to its philosophy and goals and evolve to better achieve the aims of high quality, safe, equitable, and affordable healthcare. I am confident, knowing and respecting the expertise of those who practice case management, you are more than up to the challenges you face today and in the future. And the most important message, as you read and practice these standards, please remember your work

is incredibly important to the people you serve. It is critical to the well-being and satisfaction of the members of your interprofessional teams and to the strength and impact of our healthcare system.

Gerri Lamb, PhD, RN, FAAN
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Preface

The 2022 Standards of Practice represents the extraordinary work of case management professionals with over 300 combined years of experience. The authors and reviewers have been on a journey to professionalize the practice of case management as an advanced enhancement to licensed clinical practice for nurses, pharmacists, psychologists, and social workers for decades. The journey began in 1995 when clinical professionals embarked upon lifelong careers to assist, advocate, support and teach patients/clients to navigate an often-complex system of healthcare while balancing the need to find cost-effective solutions for all parties. Over the years, many dedicated case managers leveraged academia, healthcare trends, policy decisions, research, and process improvement studies to rigorously evolve a set of standards designed to guide and normalize case management practice.

Today, the Case Management Society of America (CMSA) definition of case management serves as the industry standard for professional case management and is referenced throughout healthcare literature. The CMSA Standards of Practice provide further clarity and uniformity that benchmarks the care patients/clients receive from licensed, professional case managers. These Standards of Practice provide the criterion for professional case management and are consistent with prevailing practices in various settings. The case management process demonstrates specificity and the clinical paradigm to guide holistic, patient-centered care, no matter the environmental context of care delivery. Individuals, organizations, institutions, and companies can use these Standards of Practice as the foundational document for outcome measures, professional development, and personnel competencies. The Standards of Practice are grounded in ethical principles and inclusive enough to accommodate multiple levels of practice along the care continuum from point of care to supervisory leadership. The authors' intent is to provide readers/users with a set of standards to level-set references to multiple titles that describe the practice of case management. These Standards of Practice define professional case management and describe associated behaviors for licensed professionals engaged in this specialty.

Finally, these standards are written such that a case manager can be effective in patient-centered care in "usual times" or "extraordinary" times such as a global pandemic, mass casualty event or natural disaster. The expert experienced and passionate team of writers and reviewers coalesced around the production of a document that is timeless, apolitical, and inclusive, such that

practice behaviors accommodate the inevitable changes within the healthcare industry. The diversity of authorship and reviewers confirms the generational and multidisciplinary appeal to case managers around the world. I applaud the diversity of thought from case management leaders who were serious and committed to the CMSA Standards of Practice as the principal guide for those who want to elevate their practice, enhance careers, and advance the body of knowledge for professional case management.

Melanie A. Prince, MSS, MSN, RN, NE-BC, CCM, FAAN
CMSA President, 2020 -2022

I. Introduction

The delivery of high-quality health care that yields cost-effective outcomes continues to be an overarching goal of any nation's healthcare system. In the United States of America, the cost of care remains high in many segments of the healthcare market, but the pursuit of quality healthcare has not diminished. Over the past decades, advances in technology, complex payer models, federal and state legislation, health care professional roles, and the American economy at large have added challenges to an already complex health care system. In 2019, the emergence of the SARS-CoV-2 virus and the subsequent coronavirus disease 2019 (COVID-19) incidence resulted in a global pandemic that placed unprecedented stress on the healthcare system as America and other countries managed an expensive and deadly infectious disease outbreak. In addition, since many people's healthcare insurance is tied to employment, the consequences of job loss and a slowed economy due to the pandemic expanded the cohort of uninsured or underinsured across the country. Despite the cost of health care, the complexity of the delivery system, and the unprecedented burdens of supply and demand placed on healthcare personnel, the patient care experience is the priority and must be timely, safe, and high quality. The case management practice by professional nurses, social workers, pharmacists, physicians, and other licensed personnel improves access to services, drives better health outcomes, lowers costs, and ensures safe transitions of care across the healthcare system. The delivery of high-quality health care that yields cost-effective outcomes continues to be an overarching goal of any nation's healthcare system.

This update to the Case Management Society of America's (CMSA) Standards of Practice (SOP) upholds the definition of case management and the vital role of advocating for the patient/client care experience. Additionally, this version of the SOP punctuates the global perspectives on equity in health care, the integration of mental and physical health, the impact of social determinants of health (SDOH), and the importance of licensed healthcare professionals to provide case management services in this complex and complicated healthcare delivery system. The healthcare consumer needs someone who has the appropriate education and completion of a rigorous licensing process and is practicing against a set of standards, ethical principles, and a professional code of conduct. This version of the CMSA Standards of Practice provides the foundational benchmarks and paradigms for consumers, health plans, payers, healthcare systems and

organizations, employers, federal agencies, entrepreneurs, policymakers, and academicians to utilize for education, training, process improvement, program development, accountability, and scope of practice.

To reiterate the point that case management practice continues to be grounded in professional practice and advocacy, consider the description of case management from the first edition. Professional case management fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on the quality of care, safe transitions, timely access, and availability of services. Most important is client self-determination and client-centered and culturally relevant care. These, without a doubt, enhance the health of individuals and communities. However, they also demand a professional case manager who (a) is academically prepared in a health or human services discipline; (b) possesses an unrestricted license or certification as required by the jurisdiction of employment; (c) can function independently and according to the scope of practice of the background health discipline; (d) demonstrates current knowledge, skills, and competence to provide holistic and client-centered care effectively; and (e) acts in a supervisory capacity of other personnel who are involved in the client's care but unable to function independently due to limitations of license and or education.

A cadre of professional case management experts combined over 300 years of knowledge, skills, abilities, and experience to re-tool a set of standards that will meet the challenges of today and tomorrow's healthcare system. The standards were written with the future in mind as this group of experts used predictive reasoning to anticipate the needs of consumers and providers of health care. The consensus of this diverse group of professionals on guiding principles, professional practice behaviors, a code of conduct, and the expectation for advancement on the body of knowledge is a validation of case management value to consumers and providers. In addition, the SOP reviewers further solidified the importance of the SOP and its utility for many stakeholders.

The end-user of these standards will find the same sections and categories but with enhancements in current perspectives, evidence-based sources, and criteria that support a comprehensive case management practice. Some of the terms have broader definitions, and these descriptions are located in the glossary. This version provides additional content and a comprehensive representation of the literature in the appendices. The SOPs apply to all healthcare settings and guide licensed clinicians who deliver case management services.

In some settings, case managers may be referred to as care managers, but the expectation is the practitioner is a professional. These SOPs are relevant for care managers if their practice and services are consistent with these principles, benchmarks, and codes of conduct. The term care coordinator is also used within this practice community, but case management and care management incorporate far more than care coordination. Care coordination is one aspect of the case and care management, typically describing services related to care transitions. The CMSA Standards of Practice are current, foundational, evidence-based, relevant and valid, comprehensive and aspirational for a modern, innovative, and futuristic application to the professional practice of case management now and into the future.

Note: Evolution of the Standards of Practice for Case Management will now be included in the Appendices.

II. Definition of Case Management

The basic concept of case management involves the timely coordination of quality services to address a client's specific needs cost-effectively and safely to promote optimal outcomes. This can occur in a single health care setting or during the client's transitions of care throughout the care continuum. In addition, the professional case manager serves as an essential facilitator among the client, family or caregiver, the interprofessional health care team, the payer, and the community. The definition has evolved since first drafted in 1993. More information can be found in the Reference section of this document.

In 2016, the CMSA Board of Directors included client safety in the updated definition, and this definition is still relevant:

"Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes."

Explaining case management to clients and the public can sometimes be challenging. The following is a definition that can be used for clients and the public:

"Case managers are healthcare professionals who serve as patient advocates to support, guide and coordinate care for patients, families, and caregivers as they navigate their health and wellness journeys."

III. Philosophy and Guiding Principles

A. Statement of Philosophy

Philosophy is a statement of belief and values that sets forth principles to guide a program, its meaning, its context, and the role of the individual(s) that exist in it. For example, the CMSA philosophy of case management articulates that:

The underlying premise of case management is based on the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individual client being served, the client's family or family caregiver, the health care delivery system, the reimbursement source or payer, and other involved parties such as the employer and healthcare advocates.

Professional case management serves to achieve client wellness and autonomy through advocacy, ongoing communication, health education, identification of service resources, and service facilitation.

Professional case management services are best offered in a climate that advances client engagement and empowerment with direct communication among the case manager, the client, the client's family or support system, and appropriate service personnel to facilitate desired outcomes.

The philosophy of case management underscores the recommendation that at-risk individuals, especially those with complex medical, behavioral, and psychosocial needs, be evaluated for case management interventions. The key philosophical components of case management address holistic and client-centered care, with mutual goals, stewardship of resources for the client and the health care system, and diverse stakeholders. Through these efforts, case management focuses simultaneously on achieving optimal health and attaining wellness to the highest level possible for each client.

It is the philosophy of case management that when health care is effective and efficient, all parties benefit. Case management, provided as part of a collaborative and interprofessional health care team, identifies options and resources acceptable to the client and the client's family or support system. This then, in turn, increases the potential for effective client engagement in self-management, adherence to the plan of care, and the achievement of desired outcomes.

Case management interventions focus on improving care coordination and transitions and reducing the fragmentation of the services the recipients of care

often experience, especially when multiple health care providers and different care settings are involved. Collectively, case management interventions enhance client safety, well-being, and quality of life.

These interventions carefully consider health care costs through the professional case manager's recommendations of cost-effective and efficient alternatives for care. Thus, effective case management directly and positively impacts the health care delivery system, especially in realizing the goals of the "Triple Aim," which include improving the health outcomes of individuals and populations, enhancing the experience of health care, and reducing the cost of care.

B. Guiding Principles

Guiding principles are relevant and meaningful concepts that clarify or guide practice. Guiding principles for case management practice provide those professional case managers:

- Use a client-centric, collaborative partnership approach that is responsive to the individual client's culture, preferences, needs, and values.
- Facilitate client's self-determination and self-management through the tenets of advocacy, shared and informed decision-making, counseling, and health education, whenever possible.
- Use a comprehensive, holistic, and compassionate approach to care delivery that integrates a client's medical, behavioral, social, psychological, functional, and other needs.
- Practice cultural and linguistic sensitivity and maintain current knowledge of the diverse populations served.
- Implement evidence-based care guidelines in the care of clients, as available and applicable to the practice setting, or client population served.
- Promote optimal client safety at the individual, organizational, and community levels.
- Promote behavioral change science and principles integration throughout the case management process.
- Facilitate awareness of and connections with community supports and resources.
- Foster safe and manageable navigation through the health care

system to enhance the client's timely access to services and achieve desired outcomes.

- Pursue professional knowledge and practice excellence and maintain competence in case management and health and human service delivery.
- Support systematic approaches to quality management and health outcomes improvement, implementation of practice innovations, and dissemination of knowledge and practice to the health care community.
- Maintain compliance with federal, state, and local rules and regulations and organizational, accreditation, and certification standards.
- Demonstrate knowledge, skills, and competency in applying case management standards of practice and relevant codes of ethics and professional conduct.
- Support clients and their support systems with access to available and advancing technologies such as applications, patient portals, and telehealth services.

Case management guiding principles, interventions, and strategies target the achievement of optimal wellness, function, and autonomy for the client and client's family or family caregiver through advocacy, assessment, planning, communication, health education, resource management, care coordination, collaboration, and service facilitation.

The professional case manager applies these principles into practice based on the individualized needs and values of the client to assure, in collaboration with the interprofessional health care team, the provision of safe, appropriate, effective, client-centered, timely, efficient, and equitable care and services.

IV. Case Management Practice Settings

Professional case management practice spans all health care settings across the continuum of health and human services. This may include the payer, provider, government, employer, community, and client's home environment. The practice varies in degrees of complexity, intensity, urgency, and comprehensiveness based on the following four factors:

A. The care context includes wellness and prevention, acute, subacute and rehabilitative, skilled, serious, or life-limiting illness.

B. Health and behavioral health conditions, needs of the client population(s) served, and those of the client's family or caregivers.

C. Reimbursement methods applied, such as managed care, workers' compensation, Medicare, or Medicaid.

D. Professional disciplines of the designated case manager may include occupational therapist, pharmacist, physician, physical therapist, registered nurse, speech therapist, social worker.

The following is a representation, though not exhaustive, list of practice settings. However, it is a reflection of where professional case managers practice today, whether in-person or virtually:

- Ambulatory care clinics and community-based organizations
- Federally Qualified Health Centers
- Student or university counseling and health care centers
- Medical and health homes
- Primary care practices
- Corporations
- Geriatric services including residential, senior centers, assisted living facilities and continuing care retirement communities
- Government-sponsored programs such as correctional facilities, military health, and Veterans Administration, and public health
- Hospitals and integrated care delivery systems, including acute care, sub-acute care, long-term acute care (LTAC) facilities, skilled nursing facilities (SNFs), and rehabilitation facilities
- Independent and private case management companies
- Lifecare planning programs

- Long-term care services, including home, skilled, custodial, and community-based programs
- Population health, wellness and prevention programs, and disease and chronic care management companies
- Private health insurance programs including workers' compensation, occupational health, catastrophic and disability management, liability, casualty, automotive, accident and health, long-term care insurance, group health insurance, and managed care organizations
- Provider agencies and community-based facilities, including mental/behavioral health facilities, home health services, ambulatory and daycare facilities
- Public health insurance and benefit programs such as Medicare, Medicaid, and state-funded programs
- Primary care and specialty group practices, Patient-Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACOs) and Physician-Hospital Organizations (PHOs)
- Schools
- Serious illness, hospice, palliative, and respite care programs

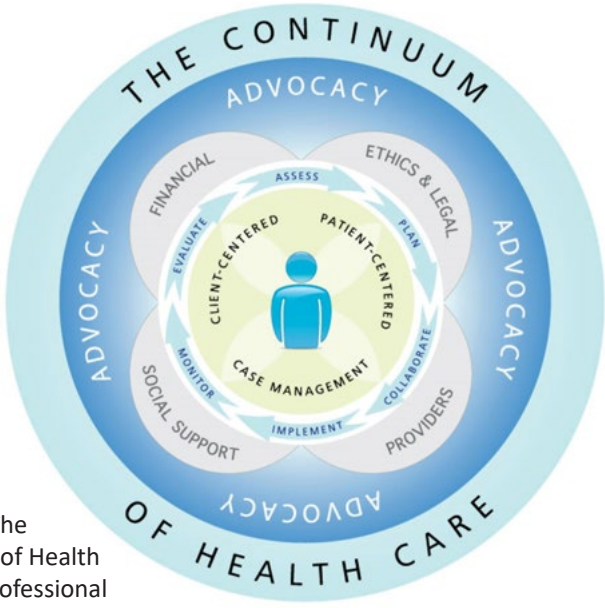

FIGURE 1: The Continuum of Health Care and Professional Case Management

V. Professional Case Management Roles and Responsibilities

The role of a Professional Case Manager concerning the patient is that of advocacy. Advocacy is used to coordinate the influential factors that affect the patient or a group of patients' ability to achieve their optimum state of health. The contributing factors to well-being include Financial, Ethics and Legal, Social Support, and Providers of care. See Figure 1.

The Professional Case Manager is responsible for being patient-centered and is held accountable to maintain the education and skills needed to deliver quality care. The professional case manager should demonstrate knowledge of health insurance and funding sources, health care services, human behavior dynamics, health care delivery and financing systems, community resources, ethical and evidence-based practice, applicable laws and regulations, clinical standards and outcomes, and health information technology and digital media for effective and competent performance.

As the Professional Case Manager executes the case management process, the specific roles and responsibilities may vary based on their health discipline background and the environment or care setting in which they practice. A job description sums up each unique practice site's discrete tasks, functions, and responsibilities.

VI. Components of the Case Management Process

The case management process is carried out within the ethical and legal realms of a case manager's scope of practice, using critical thinking and evidence-based knowledge. The overarching themes in the case management process include the activities described below.

Note that the case management process is cyclical and recurrent rather than linear and unidirectional. For example, critical functions of the professional case manager, such as communication, facilitation, coordination, collaboration, and advocacy, occur throughout all the steps of the case management process and in constant contact with the client, client's family or caregiver, and other members of the interprofessional health care team. Primary steps in the case management process include Client Identification, Selection, and Engagement in Professional Case Management:

- Focus on screening clients identified or referred by other professionals for case management as appropriate for services and the potential benefit from services.
- Engagement of the client and family or caregiver in the process.
- Obtain consent for case management services as part of the case initiation process.
- Assessment and Opportunity Identification:
  - » Assessment begins after screening, identification, and engagement in case management. It involves data gathering, analysis, and synthesis of the information to develop a client-centric case management plan of care.
  - » Assessment helps establish the client-case manager relationship and the client's readiness to engage in own health and well-being. It requires practical communication skills such as active listening, meaningful conversation, motivational interviewing, and the use of open-ended questions.
  - » Care needs and opportunities are identified by analyzing the assessment findings and determining identified needs, barriers, or gaps in care.
  - » Assessment is an ongoing process occurring intermittently, as needed, to determine the efficacy of the case management plan of care and the client's progress toward achieving target goals.
  - » Assessment should cover medical, behavioral health, substance

use and abuse, and social determinants of health.

- Development of the Case Management Plan of Care:
  - » The case management plan of care is a structured, dynamic tool used to document the opportunities, interventions, and expected goals the professional case manager applies during the client's engagement in case management services. It includes:
  - » Identified care needs, barriers, and opportunities for collaboration with the client, family or caregiver, and members of the interprofessional care team to provide more effective integrated care;
  - » Prioritized goals and outcomes to be achieved; and;
  - » Interventions or actions needed to reach the goals.

Client and client's family or caregiver input and participation in developing the case management plan of care is essential to promote client-centered care and maximize the potential for achieving the target goals.

- Implementation and Coordination of the Case Management Plan of Care:
  - » The case management plan of care is implemented by coordinating care, services, resources, and health education specified in the planned interventions.
  - » Effective care coordination requires ongoing communication and collaboration with the client and client's family or caregiver, the provider, and the interprofessional healthcare team.

- Monitoring and Evaluation of the Case Management Plan of Care:
  - » Ongoing follow-up with the client, family, and caregiver and evaluation of the client's status, goals, and outcomes.
  - » Monitoring activities include assessing the client's progress with planned interventions.
  - » Evaluating care goals and interventions to determine if they remain appropriate, relevant, and realistic.
  - » Making any revisions or modifications needed to the care needs, goals, or interventions specified in the client's case management plan of care.

- Closure of the Professional Case Management Services:
  - » Mutual decision to discontinue case management services
  - » Case closure focuses on discontinuing professional case management services when the client has attained the highest level of functioning and recovery, the best possible outcomes, or when the needs and desires of the client have changed.

VII. Standards of Professional Case Management Practice

A. Standard: Qualifications

The professional case manager should maintain competence in the area(s) of practice by having one of the following:

- A current, active, and unrestricted licensure or certification in a health or human services discipline allows the professional to conduct an assessment independently as permitted within the discipline's scope of practice.
- The individual who practices in a state that does not require licensure or certification must have a baccalaureate or graduate degree in social work or another health or human services field that promotes the physical, psychosocial, or vocational well-being of the persons being served. In addition, the degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization and:
- The individual must have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

How Demonstrated:

- Possession of education, experience, and expertise required for the professional case manager's area(s) of practice.
- Compliance with national, state, and local laws and regulations that apply to the jurisdiction(s) and discipline(s) applicable to the professional case manager practice.
- Maintain competence through participation in relevant and ongoing continuing education, certification, academic study, and internship programs.
- Practice within the professional case manager's area(s) of expertise, making timely and appropriate referrals, and seeking consultation with other professionals when needed.
- Supervision: See the Appendices for more information
- The professional case manager acts in a supervisory or leadership role of other personnel who cannot function independently due to

limitations of license or education.

- Due to the variation in academic degrees and other educational requirements, it is recommended that individuals interested in pursuing a professional case management career seek guidance as to the appropriate educational preparation and academic degree necessary to practice case management. In addition, these interested individuals may seek the Case Management Society of America, American Nurses Association, Commission for Case Manager Certification, or other relevant professional organizations for further advice and guidance.
- See the Appendices for more information about Social Work

B. Standard: Professional Responsibilities

The professional case manager should engage in scholarly activities such as contributing to curricula and maintaining familiarity with current knowledge, competencies, case management-related research, and evidence-supported care innovations. The professional case manager should also identify best practices in case management and health care service delivery and apply such in transforming practice, as appropriate. Finally, the professional case manager should provide the highest quality care by staying informed of the latest innovations and best practices in health care delivery.

How Demonstrated:

- Incorporate current and relevant research findings into one's practice, including policies, procedures, care protocols or guidelines, and workflow processes applicable to the care setting.
- Efficient retrieval and appraisal of research evidence of one's practice and client population served.
- Proficient in the application of research-related and evidence-based practice tools and terminologies.
- Ability to identify and review evidence-based and peer-reviewed materials (e.g., research results, publications) and incorporate them into a professional practice of case management as available and appropriate.
- Accountability and responsibility for one are professional development and advancement.
- Participation in ongoing training or educational opportunities (e.g.,

conferences, webinars, academic programs) to maintain and enhance one's knowledge, skills, and abilities relative to the professional practice of case management.

- Participate in research activities that support the quantification and definition of valid and reliable outcomes, especially those that demonstrate the value of case management services and their impact on the individual client and population health.
- Identify and evaluate best practices and innovative case management interventions.
- Leverage opportunities in the employment setting to conduct innovative performance improvement projects and formally report on their results.
- Publish or present at conferences, disseminate practice innovations, research findings, evidence-based practices, and quality or performance improvement efforts.
- Participate in professional case management-related associations and local, regional, or national committees and task forces.
- Mentor and coach less experienced case managers, interprofessional health care team members, and providers.

C. Standard: Legal

The professional case manager shall adhere to all applicable federal, state, and local laws and regulations, which have full force and effect of law, governing all aspects of case management practice including, but not limited to, client privacy and confidentiality rights. It is the responsibility of the professional case manager to work within the scope of their license or underlying profession.

NOTE: If the professional case manager's employer policies or other entities conflict with applicable legal requirements, the case manager should understand that the law prevails. In these situations, case managers should seek clarification of questions or concerns from an appropriate and reliable expert resource, such as a legal counsel, compliance officer, or an appropriate government agency.

Confidentiality and Client Privacy

The professional case manager should adhere to federal, state, and local laws and policies and procedures governing client privacy and confidentiality. In addition, the professional case manager should act in a manner consistent with

the client's best interest in all aspects of communication and recordkeeping, whether through traditional paper records or electronic health records (EHR).

NOTE: Federal law preempts (supersedes) state and local law and provides a minimum mandatory national standard; states may enlarge client rights but not reduce them. For those who work exclusively on federal enclaves or tribal lands, any issues of concern should direct them to the licensing authority or federal law.

How Demonstrated:

- The professional case manager shall demonstrate up-to-date knowledge of and adherence to applicable laws and regulations concerning confidentiality, privacy, and protection of the client's medical information.
- Evidence of reasonable effort to obtain the 'client's written acknowledgment they received notice of privacy rights and practices.
- The professional case manager should obtain appropriate informed consent before implementing case management services.
- Evidence that the client or client's caregiver or support system have been thoroughly informed concerning:
- Proposed case management process and services relating to the 'client's health condition(s) and needs
- Possible benefits and costs of such services
- Alternatives to proposed services
- Potential risks and consequences of proposed services and alternatives; and,
- The right to decline the proposed case management services and awareness of risks and consequences of such a decision.
- Evidence that the information was communicated in a client-sensitive manner permits the client to make voluntary and informed choices.
- Document informed consent where client consent is a prerequisite to case management services.

D. Standard: Ethics

The professional case manager should behave and practice ethically and adhere to the tenets of the code of ethics that underlie their professional discipline.

How Demonstrated:

- Documentation should reflect:
- Awareness of case management's five fundamental ethical principles and how they are applied. These are:
- Autonomy (to respect individuals' rights to make their own decisions),
- Beneficence (to do good),
- Fidelity (to follow-through and to keep promises),
- Justice (to treat others fairly), and
- Nonmaleficence (to do no harm)

Recognition of obligations:

- First to clients cared for
- Second, to engage in and maintain cooperative and respectful relationships with employers, coworkers, and other professionals.
- Third, to maintain personal and occupational health, safety, and integrity, and,
  - » Laws, rules, policies, insurance benefits, and regulations may conflict with ethical principles. In such situations, the professional case manager must address the conflicts to the best of their abilities or seek appropriate consultation.
  - » View clients as unique individuals whom case managers should engage without regard to disability, familial preference, gender identity, sexual orientation, race or ethnicity, national origin, migration, background, religion, socioeconomic status, geographic location, or other cultural considerations, and,
  - » Enact policies to ensure universal respect of the integrity and worth of each person.
  - » The needs of society as a whole by recognizing the complexities and impact on health and well-being that inequity and disparity, bias, exclusion, racism, and injustice caused, but address individually.

E. Standard: Advocacy

The professional case manager will seek creative ways to advocate for clients' best interests. For example, case managers will pursue education to further their knowledge base, skill set, and practice to provide clients with the most

current information relevant to their health situation. The case manager will also advocate for high-quality care for the client that uses evidence-based practices in the appropriate delivery systems, to include:

- Promote the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy.
- Educate other health care and service providers in recognizing and respecting the client's needs, strengths, and goals.
- Facilitate client access to necessary and appropriate services while educating the client, caregiver, and support system about resource availability within practice settings.
- Recognize, prevent, and eliminate disparities in accessing high-quality care.
- Promote optimal client health care outcomes as they relate to race, ethnicity, national origin, and migration background; sex and marital status; age, religion, and political belief; physical, mental, or cognitive disability; gender orientation; or other cultural factors.
- Advocate for appropriate levels of care, timely and well-coordinated transitions, and allocations of resources to optimize outcomes.
- Advocate for expansion or establishment of services and client-centered changes in organizational and governmental policy.
- Address the need for a diverse and inclusive workforce to improve social determinants of health and inequities in the health care system.
- Ensure a safety culture by engagement in quality improvement initiatives in the workplace.
- Encourage the establishment of client, caregiver, and support system advisory councils to improve client-centered care standards within the organization.
- Join relevant professional organizations in call-to-action campaigns, whenever possible, to improve the quality of care and reduce health disparities.
- Recognize that client advocacy can sometimes involve a conflict with the need to balance cost constraints. Therefore, the role of case management includes balancing fiscal responsibility with advocacy.

F. Standard: Cultural Competency

The professional case manager should maintain sensitivity and awareness to cross-cultural differences and be responsive to the cultural and linguistic diversity of the demographics of their work setting and the specific client and caregiver needs.

How Demonstrated:

- Evidence of communicating in a practical, respectful, and sensitive manner and following the client's cultural and linguistic context.
- Complete assessments, set goals, and develop a case management plan to accommodate cultural and linguistic needs and services preferences.
- Identify appropriate resources to enhance the client's access to care and improve health care outcomes. These may include the use of interpreters and health educational materials which apply language and format demonstrative of understanding of the client's cultural and linguistic communication patterns, including but not limited to speech volume, context, tone, kinetics, space, and other similar verbal/non-verbal communication patterns.
- Pursue professional education to maintain and advance 'one's cultural competence and effectiveness while working with diverse client populations.

G. Standard: Resource Management

The professional case manager should integrate factors compliant with requisite employer standards regarding patient access, choice, cost, health equity, quality, and safety; all should be aligned with CMSA's standards of practice.

The professional case manager should document evidence of aligning the most effective and efficient use of health and behavioral health services and financial resources when designing a plan of care.

How Demonstrated:

- Documentation of:
  - » Evaluation of safety, effectiveness, cost, and target outcomes to promote ongoing care needs of the client
  - » Application of evidence-based guidelines and practices when recommending resource allocation and utilization options,

- » Provision of client, family, or caregiver connection to cultural and linguistically appropriate resources to meet the needs and goals identified in the plan of care
- » Communication with client, family, or caregiver about the length of time for availability of identified resources
- » Ensured transparency regarding patient financial responsibility associated with a resource, and the range of potential associated outcomes related to resource utilization
- » Communication with the interdisciplinary health care team during care transitions or when a significant change in the client's situation occurs.
- » The intensity of the case management service corresponds with the client's needs.

H. Standard: Health Information Technology

HIT is intended to improve communication patient care, reduce costs, increase efficiency, and improve patient outcomes. The case manager will take responsibility for learning new technologies and participating in ongoing use, especially with predictive analytics and resource optimization.

How demonstrated:

- Adherence to standards, regulations, existing local municipal, state, and federal laws, and employer requirements
- Assist clients and their support systems with access to available technologies such as applications, patient portals, telehealth services, etc.
- Understand how information is used, where it goes, and who has access to that information
- Inform, educate, teach, and guide clients on how to access technology and monitor outcomes

I. Standard: Client Selection

How individuals are selected for case management intervention requires a process that appropriately identifies those who will reap the most benefit. Case management programs are most effective when clients have illnesses or conditions that benefit from case management interventions. The development of effective and efficient case management services and programs require expansion of focus, beginning with the acute care setting advancing to

encompass the entire continuum of care. The care continuum includes but is not limited to care access, caregiver support, behavioral health, socioeconomic status, health literacy, cultural preference, and any other social determinant that could impact health.

Identification of individuals or populations appropriate for case management programs may include multiple methods, but the selection should be made with the intent of benefit. These methods include a referral from other professionals, diagnosis-based regression models, risk assessments, predictive algorithms, and claims and pharmacy data. Screening of clients should be conducted without bias and be guided by the intent of health equity and ethical decision-making processes. The individual case manager's profession or organization guides the evaluation of an individual's candidacy for professional case management services inclusive of the ethics and scope of practice specific to the case management professional.

How Demonstrated:

- Candidates for case management should be those with the greatest need.
- Use screening criteria as appropriate to select a client for inclusion in case management. Examples of screening criteria may include, but are not limited to:
    - High emergency department use
    - High outpatient utilization
    - Avoidable hospital admissions
    - Complex health needs
    - Multiple chronic conditions
    - Barriers to accessing care and services
    - Developmental disabilities are complicated by complex or chronic illnesses
    - History of mental illness, substance use, suicide risk, or crisis intervention
    - Impaired functional status or cognitive deficits
- Complex health conditions complicated by socioeconomic needs such as:
    - Housing and transportation needs

- Food insecurity
- Forms of abuse, neglect, or trauma
- Financial concerns
- Complex health needs with lack of adequate social support, including caregiver support
- Complex health needs and low health literacy, reading literacy, or numeracy literacy levels

- Use analytics that demonstrate the risk of high utilization and cost expected in the next one to five years
- Best practice guides documentation of the referral source and method. To improve the potential for health improvement, assure screening of referrals is completed timely to improve client engagement while supporting the case manager's caseload in times of limited resources.
- A client, family, or caregiver request professional case management services.

J. Standard: Client Assessment

The professional case manager should complete a thorough individualized client-centered assessment that considers the client's unique cultural and linguistic needs, including their support network as appropriate.

Client assessment is a process that focuses on the evolving needs of a client as identified by the case manager throughout the professional relationship and across the transitions of care. Client assessment involves each client and the client's family or support network as appropriate. It includes the physical, psychological, social, environmental, and spiritual domains as pertinent to the practice setting access care.
The case manager shall engage clients—and, when appropriate, other members of the client's support network in an ongoing information gathering and decision-making process to assess health needs.

Case management assessments are conducted to connect available care and resources to address the client's illness, conditions, or care complexity. Assessment is a complex function requiring openness to a wide variety of verbal and nonverbal information presented by the client—and, when appropriate, other members of the client's support system. Using empathy, client-centered

interviewing skills, and methods appropriate to clients' capacity, the case manager engages clients in identifying their needs, strengths, and challenges about health improvement and self-management. Based on this discussion, the case manager supports the client in establishing priorities and goals. Because the assessment guides care coordination and implementation, the case manager needs to complete initial assessments promptly.

Assessment is an ongoing activity, not a one-time event. During the reassessment process, the case manager and client (and, if appropriate, other members of the client's support system) revisit the needs, assets, and priorities identified in the initial assessment and discuss the client's emerging concerns. Reassessment serves both monitoring and evaluative functions, enabling the case manager and the client to determine whether services have been effective in helping achieve the client's goals. Based on such reassessment, the case manager and the client may determine that case management goals or the care plan need to be adjusted.

Throughout the assessment and reassessment process, some case managers may find standardized (CMSA Best Practices) instruments helpful in identifying and responding to the client's concerns. Such instruments can be used as a starting point in developing and refining an individualized, comprehensive assessment. The purpose of any tool or instrument should be explained to the client in detail.

Case management assessments are rooted in the profession's priority of person-centered care and advocacy, ensuring the client is at the center of every initiative, action, plan, or intervention. Assessments may vary based on organizational setting and practice specialty and should reflect each client's individual needs and strengths. Likewise, it can vary from one practice setting to another. Its identifying characteristics depend on the discipline that uses it, the personnel and staff mix used, and the setting in which the model is implemented. Many commercially available and proprietary assessments are too numerous to list but may focus on a particular illness, diagnosis, condition, or disability. Throughout the assessment, the case manager should be tuned to the congruence between goals and expectations of the client, structure, and philosophy of the case management program.

How Demonstrated:

- Document the client assessments using standardized tools, both electronic and written, commercial or proprietary, when appropriate. The assessment may include, but is not limited to the following

components:

- Complete an assessment of the total individual, including physical, psychological, social, environmental, and spiritual needs.

The following are examples of assessments based on the stated health domains. However, specific assessments required or recommended by organizations and institutions may not be included.

Physical domain Assessments may include:

- Presenting health status and conditions
- Personal health history
- Medical history inclusive of diagnosed conditions or illnesses, prescribed treatment, response to treatment, symptomatology, medical interventions
- The current medication regime includes prescribed or over-the-counter medications and herbal products or plant-based medicines.
- Prognosis
- Nutritional status, including Body Mass Index (BMI).
- Health care providers involved in client's care
- Diagnostic testing results are known or pending.

Psychological Assessments may include:

- Current mental health status
- History of substance use
- History of depression, anxiety, or trauma
- History of behavioral health treatment
- Cognitive functioning
- Capacity to make informed decisions.
- Learning and technology capabilities

Social Assessments may include:

- Family or caregiver dynamics
- Caregiver resources: availability and degree of involvement
- Current or former employment/work environment

- Client social, cultural, values, needs, and preferences.
- Recreational and leisure pursuits
- History of neglect, abuse, violence, or trauma
- Advanced directives planning and availability of documentation.
- Pertinent legal situations (e.g., custody, marital discord, and immigration status)

Environmental Assessments may include:

- Living environment, residence, financial circumstances
- Safety concerns and needs
- Access to healthy foods
- Health insurance status and availability of health care benefits
- Language and communication preferences, needs, or limitations
- Client priorities, care goals, strengths, and abilities
- Functional status
- Access to care and resources
- Health literacy and activation
- Self-Management, and self-care
- Client's readiness to change or learn.
- Vocational or educational interests
- Expressive disorders
- Reading and numerical literacy
- Transitional or discharge planning needs and services, if applicable
- Skilled nursing, home health aide, durable medical equipment (DME), or other relevant services
- Transportation capability and constraints
- Follow-up care (e.g., primary care, specialty care, and appointments)
- Use of assistive technology/devices
- Internet access
- Use of technology: applications, websites, electronic personal health records, email, text

Spiritual Assessments may include:

- Spiritual beliefs and practices

Case management process and documentation:

- Reassessment of the client's condition, response to the case management plan of care and interventions, and validated metrics shall be completed to quantify progress.
- Include resource utilization and cost management documentation, provider options, and general health and behavioral care benefits.
- Provide evidence of relevant information and data required for the client's thorough assessment and obtain from multiple sources including, but not limited to:
- Client interviews.
- Initial and ongoing assessments and care summaries are available in the client's health record and across the care transitions.
- Include the client's family caregivers or support network (as appropriate), physicians, providers, and other involved members of the interdisciplinary health care team.
- Past medical records available as appropriate; and
- Claims and administrative data.

K. Standard: Identifying Care Needs and Opportunities

Recognizing the client's strengths and abilities as noted in the initial screening and ongoing assessment, the professional case manager should identify and stratify the client's care needs and opportunities that would benefit from case management interventions. These interventions may include education, communication, care coordination, resource management, and collaboration. Next, the professional case manager prioritizes the client's care needs with input from the client, the client's family or support network, and providers to reduce risk, improve health, support self-management, and create client satisfaction.

How Demonstrated:

- Documented agreement among the client and client's family or support network and other providers and organizations regarding the care needs and opportunities identified.
- Documented identification of opportunities for intervention, such as, but not limited to:
- Over-utilization or under-utilization of services and resources
- Use of multiple providers or agencies.
- Integrated care gaps or delays in care
- Use of inappropriate services or level of care.
- Lack of a primary provider or any provider
- Polypharmacy
- Financial barriers to adherence to the case management plan of care
- High-cost injuries or illnesses
- Frequent transitions between care settings or providers/readmissions
- An immediate need for transition to the next level of care.
- Need for better coordination of resources and care
- Lack of established, evidence-based plan of care with a specific goal.
- Lack of support from the client's family or support network, especially when under stress
- Non-adherence to the established plan of care (e.g., medication adherence) may be associated with the following:
- Social determinants of health
- Low reading level
- Language proficiency
- Client beliefs or values
- Lack of education or understanding of:
- Illness course or disease process
- Current condition(s)
- The medication list
- Substance use and abuse

L. Standard: Planning

The professional case manager, in collaboration with the client, client's family or caregiver, and other members of the interdisciplinary health care team, where appropriate, should identify relevant care goals and interventions to manage the client's identified care needs and opportunities. The case manager should also document these in an individualized case management plan of care.

- Documented relevant, comprehensive information and data using analysis of assessment findings, client and client's family or caregiver interviews, input from the client's interprofessional health care team, and other methods as needed to develop an individualized case management plan of care.
- Document the client and client's family or caregiver participation in developing the written case management plan of care.
- Document the client's agreement with the case management plan of care, including target goals, expected outcomes, and any changes or additions to the plan.
- Recognition of the client's needs, preferences, and desired role in decision-making concerning developing the case management care plan.
- Validation of the plan is evidence-based and incorporates clinical practice guidelines as available and applicable, and it continues to meet the client's changing needs and health condition.
- Measurable goals are defined, and outcome indicators are expected to be achieved within specified time frames. These measures could include clinical and non-clinical domains of outcomes management, such as access to care, cost-effective care, safety and quality of care, and client's experience of care.
- Evidence of supplying the client, client's family, or caregiver with information and resources necessary to make informed decisions.
- Promote awareness of client care goals, outcomes, resources, and services included in the case management care plan.
- Adherence to payer expectations concerning how often to contact and reevaluate the client, redefine long and short-term goals, or update the case management plan of care.

M. Standard: Facilitation, Coordination, and Collaboration

The professional case manager should demonstrate the skills needed to facilitate coordination, communication, collaboration with the client, support network, involved members of the interdisciplinary health care team, and other stakeholders to achieve target goals and maximize positive client care outcomes.

How Demonstrated:

- Recognize the professional case manager's role and practice setting with those of other providers and organizations that provide care and case management services to the client.
- Proactive client-centered relationships through open communication and active listening with the client, client support network, and other relevant stakeholders maximize outcomes and enhance patient safety and optimal care experience.
- Evidence of facilitation, coordination, and collaboration to support the transitions of care, including:
    - Transfers within a facility from one level of care to another.
    - Transfers of clients to the most appropriate health care provider or care setting are coordinated in a timely and complete manner.
- Document the collaborative and transparent communication between the professional case manager and other health care team members, especially during each transition to another level of care within or outside the client's current setting.
- The plan of care, target goals, and client's needs and preferences were used as a guide for facilitation and coordination of services and collaboration among members of the interdisciplinary health care team client and client support network.
- Evidence of collaboration that optimized client outcomes; may include work with the community, local and state resources, primary care providers, members of the interdisciplinary health care team, the payer, and other relevant stakeholders.
- Evidence of the use of problem-solving skills and techniques to reconcile potentially differing points of view.
- Documented adherence to client privacy and confidentiality mandates

during all aspects of facilitation, coordination, communication, and collaboration within and outside the client's care setting.

- Documentation showed adherence to regulatory and accreditation standards within the professional case manager's practice and employment setting.

N. Standard: Monitoring

The professional case manager should employ ongoing assessment and documentation to measure the client's response to the plan of care. The case manager should employ ongoing assessment, bidirectional communication, and documentation to measure the response of the client and their support system to the plan of care.

How Demonstrated:

- Document ongoing collaboration with the client, family or caregiver, providers, and other pertinent stakeholders. The client's response to interventions is reviewed and incorporated into the case management care plan.
- Awareness of circumstances necessitating revisions to the case management plan of care, such as changes in the client's condition, lack of response to the case management interventions, change in the client's preferences, transitions across care settings and providers, and barriers to care and services.
- Evidence that the plan of care continues to be reviewed and is appropriately understood, accepted by the client and client's family or caregiver, and documented.
- Sustain collaboration with the client, family or caregiver, providers, and other pertinent stakeholders regarding any revisions to the plan of care.
- Monitoring activities include assessing client's progress with planned interventions and detecting and proposing resolutions if needed with clients with multiple conditions and multiple treatment plans
- Evaluate if care goals and interventions remain appropriate, relevant, and realistic.
- Detect deviations from goals using available clinical guidelines and engage the interdisciplinary team in this process
- Determine any revisions or modifications needed to the care needs,

goals, or interventions specified in the client's case management plan of care.

O. Standard: Outcomes

Through a thorough individualized client-centered assessment, the professional case manager should maximize the client's health, wellness, safety, physical functioning, adaptation, health knowledge, coping with chronic illness, engagement, and self-management abilities.

How Demonstrated:

- Create a case management plan based on the thorough individualized client-centered assessment.
- Achieved through quality and cost-efficient case management services, client's satisfaction with care experience, shared and informed decision-making, and engagement in own health and health care.
- Evaluate the extent to which the goals and target outcomes documented in the case management plan of care have been achieved.
- Demonstrate efficacy, efficiency, quality, safety, and cost-effectiveness of the professional case manager's interventions in achieving the goals documented in the case management plan of care and agreed upon with the client and client's caregiver.
- Measure and report the impact of the case management plan of care in the following:
    - Clinical
    - Financial
    - Quality of Life
    - Patient satisfaction with care
    - Physical functioning
    - Psychosocial and emotional well-being
    - Engagement and Self-management
- Apply evidence-based adherence guidelines, standardized tools, and proven care processes. These can be used to measure the client's preference for and understanding of:

- The proposed case management plan of care and needed resources
- Motivation to change and demonstrate healthy lifestyle caregiver.

- Apply evidence-based guidelines that are relevant to the care of specific client populations.
- Evaluate client and client's family or caregiver experience with case management services.
- Use national performance measures for transitional care and care coordination such as those endorsed by the regulatory, accreditation, agencies, and health-related professional associations to enhance quality, efficiency, and optimal client experience.
- Readmission rates
- Prevented readmissions
- Lower levels of care

P. Standard: Case Closure of Professional Case Management Services

The professional case manager should appropriately complete the closure of case management services based upon established case closure guidelines. The extent of applying these guidelines may differ in various case management practices and care settings.

How Demonstrated:

- Achieve care goals and target outcomes, including those self-identified by the client and client support network.
- Identify reasons for and appropriateness of closure of case management services, such as:
- Change of health care setting which warrants the transition of the client's care to another health care provider(s) or setting
- The employer or purchaser of case management services requests the closure of case management
- Services no longer meet program or benefit eligibility requirements
- The client refuses further case management services

- Determination by the professional case manager that they are no longer able to provide appropriate case management services because of a client's ongoing disengagement in self-management and unresolved non-adherence to the case management plan of care
- Death of the client
- There is a conflict of interest
- When a dual relationship raises ethical concerns.
- Evidence of agreement for closure of case management services by the client, client support network, payer, professional case manager, or other appropriate parties.
- Evidence that when a barrier to the closure of professional case management services arises, the case manager has discussed the situation with the appropriate stakeholders and has reached an agreement on a plan to resolve the barrier.
- Documented notice for closure of professional case management services and actual closure that is based **upon the facts and circumstances of each client's case and care outcomes** supporting case closure. Evidence should show verbal or written notice of case closure to the client and other directly involved health care professionals and support service providers.
- Closed cases include documentation stating the reason for the closure and a closure summary.
- Follows established Policies and Procedures that outline the criteria and protocol for case closures.
- Evidence of client education about service or funding resources provided by the professional case manager to address any further needs of the client upon case closure.
- Completed transition of care handover to health care providers at the next level of care, where appropriate, with permission from the client, and inclusive of verbal and timely communication of relevant client information and continuity of the case management plan of care to optimize client care outcomes.
- Best Practices
- Providers attempt to reconnect clients lost to care to service. These attempts may include home visits, written/electronic correspondence,

or telephone calls and may require contact with a client's known medical and human service providers (with prior written consent).

- When services are terminated, an exit interview is conducted if appropriate.
- Case managers attempt to secure releases that will enable them to share pertinent information with a new provider.
- A management review is completed when an agency intends to terminate services related to a client who threatens, harasses, or harms staff.
- Any termination of case management services needs to be followed with resources for the client to prevent legal or ethical care breaches.

VIII. Acknowledgements

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IX. Glossary

Activity: A discrete action, behavior, or task a person performs to meet the assumed role expectations. For example, an acute care case manager "completes concurrent reviews" with a payer-based case manager.

Advocacy: The act of recommending, pleading the cause of another, to favorably speak or write.

Assessment: A systematic data collection and analysis process involving multiple elements and sources.

Care Coordination: According to the Agency for Healthcare Quality and Research (AHRQ), "Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."

Care Management: According to the Agency for healthcare quality and Research (AHRQ), "Care management is a promising team-based, patient-centered approach "designed to assist patients and their support systems in managing medical conditions more effectively. It also encompasses those care coordination activities needed to help manage chronic illness."

Care Planning: The process of assessing an individual's health, social risks and needs to determine the level and type of support required to meet those needs and objectives, and to achieve potential outcomes.

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes (CMSA, 2016; 2022).

Case Management Plan of Care: A document or electronic record that represents the synthesis and reconciliation of the multiple plans of care produced by each provider to address a Consumer's specific health concerns. The Case Management Plan of Care serves as a blueprint shared by health care team participants to guide the Consumer's care. As such, it provides the

structure required to coordinate care across multiple sites, providers, and episodes of care.

Case Management Process: How case management functions are performed, including client identification, selection, engagement, monitoring, and outcomes in case management; assessment and opportunity identification; development of the case management plan of care, including specification of care goals and target outcomes; implementation and coordination of the case management plan of care; monitoring and evaluation of the case management plan of care; closure of case management services.

Certification: A process by which a government or non-government agency grants recognition to those who have met predetermined qualifications set forth by a credentialing body.

Chronic Care Management: An approach to care that encompasses the oversight of health and human service provision and education activities conducted by health care professionals to assist individuals with one or more chronic illnesses, such as diabetes, asthma, high blood pressure, heart failure, end-stage renal disease, and HIV or AIDS, to understand their health condition and live productive lives. This approach involves motivating patients to become actively engaged in their health, adhere to necessary therapies and interventions, and achieve acceptable health outcomes, including reasonable quality of life and well-being.

Chronic Care Management Services: Reimbursable care coordination services provided to Medicare beneficiaries with two or more chronic conditions which place the beneficiary at significant risk for death, acute exacerbation, or functional decline; and require the implementation of comprehensive plans of care that are monitored over time. The services are accessible on a 24-hour-a-day, 7-day-a week basis and consist of at least 20 minutes of clinical staff time directed by a physician or another qualified health care professional during a calendar month. The services include systematic assessments of the beneficiary's medical, functional, and psychosocial needs; preventive services; a review of medication reconciliation, adherence, and self-management; and creation of client-centered care transitions.

Client: (1) An individual who is the recipient of case management services. This individual can be a patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care consumer of any age group. In addition, the term client may also infer the inclusion of the client's support.

(2) Client can also imply the business relationship with a company that contracts or pays for case management services.

Client Support System: The client's support system is defined by each client and may include biological relatives, a spouse, a partner, friends, neighbors, colleagues, a health care proxy, or any individual who supports the client.

Consumer: A person who is the direct or indirect recipient of the organization's services. Depending on the context, consumers may be identified by different names, such as "client," "member," "enrollee," "beneficiary," "patient," "injured worker," "claimant," "college student," or "resident." In addition, a consumer relationship may exist even when there is no direct relationship between the consumer and the organization. For example, suppose an individual is a member of a health plan that relies on the services of a utilization management organization. In that case, the individual is a consumer of the utilization management organization.

Cultural Competence: Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients. (1) A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care.

Culture: Culture can be defined as all the ways of life including arts, beliefs and institutions of a population that are passed down from generation to generation. Culture has been called "the way of life for an entire society." As such, it includes codes of manners, dress, language, religion, rituals, art. norms of behavior, such as law and morality, and systems of belief. Culture may include, but is not limited to, race, ethnicity, national origin, and migration background; sex, sexual orientation, and marital status; age, religion, and political belief; physical, mental, or cognitive disability; gender, gender identity, or gender expression.

Disease Management: A coordinated health care interventions and communications system for populations with conditions in which patient self-care efforts are significant. This system supports the physician or practitioner/client relationship and plan of care; emphasizes prevention of exacerbations

and complications using evidence-based practice guidelines and patient empowerment strategies; and evaluates clinical, humanistic, and economic outcomes on an ongoing basis to improve overall health. Because of the presence of co-morbidities or multiple conditions in most high-risk patients, this approach may become operationally challenging to execute, with patients being cared for by more than one program. Over time, the industry has moved more toward a whole-person model in which all the diseases a patient has are managed by a single disease management program.

Domains of Health: The World Health Organization defines health as "a state of complete physical, mental and social well-being." The University of Utah School of Medicine has identified seven domains of health and these domains impact quality of life. The identified domains are:

- physical,
- emotional,
- environmental,
- social,
- intellectual,
- financial,
- and spiritual.

Domains of Healthcare Quality: The Institutes of Medicine (IOM) put forth a framework for the development of quality measures. The framework includes the following aims:

- Safe: Avoiding harm to patients from the care that is intended to help them.
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Dual Relationships: Occur when a case manager has multiple relationships with a client, whether professional, social, or business. It is understood across interprofessional codes of ethics that dual relationships can and will occur; at times they are unavoidable. The onus is always on involved professionals to act in accordance with state laws and professional codes for their discipline, as well as organizational policies. It might be acceptable for the case manager to maintain the assignment, but a contract and/or plan should be put in place to ensure appropriate professional boundaries are maintained.
Examples:

- An individual is employed as the only case manager for a small rural community hospital within the county where he also resides. The case manager must regularly engage with clients who are neighbors, friends, and family members.
- The case manager starts a business focused on professional mentoring, offering discounts to all colleagues who contract with her, for at least six months.
- The case manager at a managed care organization is assigned a new client; she identifies the client as her son's best friend.
- The case manager has multiple part-time roles: one for a hospital, the other for an agency offering palliative care at home. The case manager receives an annual incentive bonus for increased referrals to the program. Hospital staff are informed that all patients referred to the palliative care program will be prioritized.

Evidence-Based Criteria: Guidelines for clinical practice that incorporate current and validated research findings.

Family: Family members and those individuals designated by the client as the client's support system. Family members are not limited to blood relatives; they constitute any person the client wishes to designate as family or support system.

Family Caregiver (informal): any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult with a chronic or disabling condition. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care.

Formal Caregiver: a provider associated with a formal service system, whether a paid worker or a volunteer.

Function: is a clinical operating system for the application of a patient-centered, systems biology approach to health care. Its focus is on understanding an individual's physiological, cognitive, emotional, and physical function, as well as on the design and implementation of a therapeutic program that is personalized to the functional needs of the patient. The functional assessment can be applied at many organizational levels derived from a systems network biology perspective ranging from the patient's social and spiritual functions to organ system, organ, tissue, cellular, or subcellular functional levels. The word function is aligned with the evolving understanding that disease is an endpoint and function is a process.

Handover: sometimes referred to as handoff—the transfer of authority, responsibility, and accountability for something to another individual. In the context of professional case management, handover refers to the transfer of authority, responsibility, and accountability for the care of a client to another health care professional within or outside a health care setting as indicated based on the client's needs and care goals.

Health: The definition according to the Constitution of the World Health Organization:

- Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the

public are of the utmost importance in the improvement of the health of the people.

- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Health Literacy: The degree to which individuals can obtain, process, and understand basic health information needed to make appropriate health decisions.

Health Outcomes: Changes in current or future health status of individuals, groups, or communities that can be attributed to antecedent actions or measures. The change may result from a planned intervention or series of interventions, regardless of whether such an intervention was intended to change an individual's health status.
Health Services: Medical or health and human services.

Interdisciplinary Health Care Team: Inter- or multidisciplinary teams include all members of healthcare teams, professional and non-professional. According to Nancarrow, et al, interdisciplinary teamwork is, "a dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals, and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication, and shared decision-making. This in turn generates value-added patient, organizational and staff outcomes."

Interprofessional Health Care Team: An interprofessional team is comprised of team members from two or more different professions (e.g., nurses and physicians, physicians and community health workers, social workers and psychologists, pharmacists, and respiratory therapists) who learn with, from, and about each other to enable effective collaboration and improve health outcomes.

Licensure: Licensure is a process by which a government agency grants permission to an individual to engage in each occupation, if person possesses the minimum degree of competency required to reasonably protect public health, safety, and welfare.

Managed Care: Services or strategies designed to improve access to care, quality of care, and the cost-effective use of health resources. Managed care services

include, but are not limited to, case management, utilization management, peer review, disease management, and population health.

Medical Home: A medical home model provides accessible, continuous, coordinated, and comprehensive patient-centered care and is managed centrally by a primary care physician with the active involvement of non-physician practice personnel. Providers deemed a medical home may receive supplemental payments to support operations expected of a medical home. In addition, physician practices may be encouraged or required to improve practice infrastructure and meet specific qualifications to achieve eligibility.

Outcomes: Measurable results of case management interventions, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle.

Patient Activation: Patient activation refers to patients' knowledge, skills, and confidence in self-managing health conditions. In large cross-sectional studies, individuals with higher patient activation are observed to have better health outcomes with the assumption that they are more engaged in health self-management.

Patient Engagement: Patient engagement is both process and behavior and is shaped by the relationship between the patient and provider and the environment in which healthcare delivery takes place.

Payer: An individual or entity that funds related services, income, or products for an individual with health needs.

Predictive Modeling: Modeling is the process of mapping relationships among data elements that have a common thread. Data are "mined" with predictive modeling software to examine and recognize patterns and trends, potentially forecasting clinical and cost outcomes. This allows an organization to make better decisions regarding current/future staff and equipment expenditures, provider and client education needs, allocation of finances, and better risk stratifying population groups.

Provider: The individual, service organization, or vendor who provides health care services to the client.

Risk Stratification: The process of categorizing individuals and populations according to their likelihood of experiencing adverse outcomes, e.g., high risk for hospitalization.

Role: A general and abstract term that refers to a set of behaviors and expected consequences associated with one's position in a social structure. A role consists of several functions which constitute what is commonly known as a "job description." Each function in a role is described through a list of specific and related activities. Usually, organizations and employers use a person's title as a proxy for their role, for example, "acute care case manager" (Tahan & Campagna, 2010).

Standard: An authoritative statement agreed to and promulgated by the practice based on the quality of practice and service.

Stewardship: Responsible and fiscally thoughtful management of resources.

Transitional Care: Transitional care includes all the services required to facilitate the coordination and continuity of health care as the client moves between one health care service provider and another.

Transitions of Care: Transitions of care are the movement of patients from one health care practitioner or setting to another as their condition, and care needs change. Also known as "care transitions."

Value-Based Purchasing: A program provided by the Centers for Medicare & Medicaid Services as part of the Patient Protection and Affordable Care Act of 2010. This program rewards providers with incentive payments based on the quality of care delivered to Medicare beneficiaries, how closely best clinical practices are followed and enhances the patient experience.

X. Appendices

Appendix A

Standard A. Case Manager Qualifications: Social workers who are prepared at the Master's in Social Work (MSW) degree level and educated under a program that would preclude them from sitting for licensure (where required) or practice at the clinical level should consult with their state licensing board to determine if additional education and/or practicum hours are required.

Appendix B

Standard B. Client Assessment: A multitude of assessments are available including those that target specific conditions. These can include cognitive, food insecurity, disease-specific (i.e., diabetes), depression, anxiety or other mood disorders, physical function, and quality of life. Physical disease-specific assessments can be located using a simple internet search or accessing websites for specific conditions. Many organizations develop proprietary assessment tools based on customer requirements. For example, state Medicaid plans' required assessments will differ based on the needs identified in each state population.

Examples of specialty assessments:

- GAD-7 assesses anxiety
- PHQ-9 assesses depressive symptoms
- Patient Activation Measure (PAM): assesses client engagement
- Accountable Health Communities Health-Related Social Needs Screening Tool: assesses social determinants of health
- Multidimensional Scale of Perceived Social Support (MSPSS)
- Pain rating or assessments of pain's impact on function examples
    - WILDA (Words to describe the pain; Intensity; Location; Duration; and Aggravating and Alleviating factors)
    - NRS (Numerical Rating Scale)
    - Defense and Veterans Pain Rating Scale (DVPRS)
    - Pediatric: Faces, Legs, Activity, Cry and Consolability (FLACC)
    - Behavioral Pain Scale (BPS)
- Healthcare Quality of Life examples
    - HRQoL (Health-Related Quality of Life scale)
    - PROMIS (Patient-Reported Outcomes Measurement

System)
- Spiritual Assessment examples
  - FICA Spiritual History Tool
  - HOPE Questions for Spiritual Assessment

Appendix C

Case Management Model Act
Case Management is Essential to Population Health

1. Title Protection for Case Management — Case managers are licensed professionals with the experience to support consumers and their families. Several professional groups, including the Case Management Society of America (CMSA), develop and maintain professional standards of practice, along with several nationally recognized certification bodies. Using non-licensed/certified individuals for case management can jeopardize patient care and creates opportunities for fraud.

2. Promoting Clinical Outcomes — The Case Management Model Act addresses many of the key building blocks to improve clinical outcomes. Case management is a collaborative process of assessing, planning, facilitating, coordinating and evaluating, to meet a consumer and their family's comprehensive health needs.

3. Optimizing Value-Based Purchasing — The Model Act can be configured to be national in scope or more targeted to support a range of value-based purchasing initiatives. Case managers can serve as the lynchpin on many initiatives, including collaborative care, to improve quality while optimizing the health care dollar-spend.

4. Advancing Integration — By leveraging a wide range of resources and utilizing dynamic population health solutions, the Model Act creates a pathway to health care integration. Case management offers a unique and effective way to mobilize resources to promote transitions of care and reduce unnecessary readmissions in a variety of health care settings. One primary example is encouraging case managers to help integrate care for consumers who need both traditional medical/surgical services in conjunction with mental health and substance use disorders (MH/SUD) services.

5. Improving Quality — The Case Management Model Act promotes a systems approach to quality improvement and clearly delineates between the role of

the case manager and other support personnel, such as a navigator or case manager extender. Case management provides services that are crucial to improving quality and saving costs in a health care system where the majority of health care dollars are spent on chronic illness.

a. Facilitate Consumer Self Determination – Shared and informed decision-making, counseling, and health education. It is important to include the patient or consumer as the main decision maker.

The full document can be accessed at:
https://cmsa.org/wp-content/uploads/2020/09/2017-Model-Care-Act_Final-9.27.pdf

Appendix D

Evolution of the Standards of Practice for Case Management

1. Standards of Practice for Case Management (1995) In 1995, the President of the CMSA wrote a foreword in the 1995 CMSA Standards of Practice. In it he stated that the "development of national Standards represents a major step forward for case managers. The future of our practice lies in the quality of our performance, as well as our outcomes" (CMSA, 1995, pg.3). These first Standards included this definition of case management (CMSA, 1995, pg.8):
"Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

The 1995 Standards of Practice were recognized as an anticipated tool that case management professionals would use within every case management practice arena. They were seen as a guide to move case management practice to excellence. The Standards explored the planning, monitoring, evaluating and outcomes phases of the case management process, followed by Performance Standards for the practicing case manager. The Performance Standards addressed how the case manager worked within each of the established Standards and with other disciplines to follow all related legal and ethical requirements. Even at that first juncture, the Standards committee recognized the importance of the case managers basing their individual practice on valid research findings. The committee encouraged case managers to participate

in the research process, programs, and development of specific tools for the effective practice of case management. This was evidenced by key sections that highlighted measurement criteria in the collaborative, ethical, and legal components of the Standards (CMSA, 1995).

2. Standards of Practice for Case Management (2002)

The 2001 Board of Directors of CMSA identified the need for a careful and thorough review and, if appropriate, revision of the 1995 published Standards. The revised Standards of Practice for Case Management were then published in 2002. The previously articulated definition of case management was amended at the time to highlight the importance of the case manager's role in client advocacy (CMSA, 2002, pg. 5): "Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

The section on Performance Indicators was also expanded to further define the case manager. The purpose of case management was revised to address quality, safety, and cost-effective care, as well as to focus upon facilitating the client's appropriate access to care and services.

Primary case management functions in 2002 included both current and new skills and concepts: positive relationship-building; effective written and verbal communication; negotiation skills; knowledge of contractual and risk arrangements, the importance of obtaining consent, confidentiality, and client privacy; attention to cultural competency; ability to effect change and perform ongoing evaluation; use of critical thinking and analysis; ability to plan and organize effectively; promoting client autonomy and self-determination; and demonstrating knowledge of funding sources, health care services, human behavior dynamics, health care delivery and financing systems, and clinical standards and outcomes.

The Standards in 2002 indicated that case management work applied to individual clients or to groups of clients, such as in disease management or population health models. The facilitation section of the Standards included more detail about the importance of communication and collaboration on behalf of the client and the payer. The practice settings for case management were increased to capture the evolution of, and the increase in, the number of venues in which case managers practiced.

3. Standards of Practice for Case Management (2010)

The 2010 Standards of Practice for Case Management addressed topics that influenced the practice of case management in the dynamic health care environment while the definition of case management generally remained as that articulated in 2002. Included in the 2010 revision however were (CMSA, 2010):

- Addressing the total individual, inclusive of medical, psychosocial, behavioral, and spiritual needs.
- Collaborating efforts that focused upon moving the individual to self-care whenever possible.
- Increasing involvement of the individual and caregiver in the decision-making process.
- Minimizing fragmentation of care within the health care delivery system.
- Using evidence-based guidelines, as avail- able, in the daily practice of case management.
- Focusing on transitions of care, which included a client's transfer to the next care setting or provider while assuring effective, safe, timely, and complete transition.
- Improving outcomes by using adherence guidelines, standardized tools, and proven processes to measure a client's understanding and acceptance of the proposed plans, his/her willingness to change, and his/ her support to maintain health behavior change.
- Expanding the interdisciplinary team to include clients and/or their identified support system, health care providers, and community-based and facility-based professionals (i.e., pharmacists, nurse practitioners, holistic care providers, etc.).
- Expanding the case management role to collaborate within one's practice setting to support regulatory adherence.
- Moving clients to optimal levels of health and well-being.
- Improving client safety and satisfaction.
- Improving medication reconciliation for a client through collaborative efforts with medical staff.
- Improving adherence to the plan of care for the client, including medication adherence.

Those changes advanced case management credibility and complemented the trends and changes in the health care delivery system occurring at the time.

4. Standards of Practice for Case Management (2016)

During the 2010's revision of the Standards of Practice for Case Management, the team involved thought that future case management Standards of Practice would likely reflect the climate of health care and build upon the evidence-based guidelines that were to be proven successful in the coming years. That prediction was not far from becoming reality.

The impetus for the 2016's revision of the Standards of Practice for Case Management is the need to emphasize the professional nature of the practice and the role of the case manager. The maturity of the practice of case management, the importance of protecting the professional role of case managers, and the enactment of new laws and regulations including the Patient Protection and Affordable Care Act, all legitimize professional case management as an integral and necessary component of the health care delivery system in the United States.

It is important to note that the 2016 Standards of Practice for Case Management remain primarily like and aligned with those released in 2010 except for some modifications which are meant to communicate the value of professional case management practice and demonstrate adherence to relevant and recently enacted laws and regulations.

The revised Standards:

- Update the definition of case management to reflect recent changes in the practice.
- Clarify who the professional case manager is, and the qualifications expected of this professional.
- Emphasize the practice of professional case management in the ever-expanding care settings across the entire continuum of health and human services, and in constant collaboration with the client, client's family or caregiver, and members of the interprofessional health care team.
- Communicate practical expectations of professional case managers in the application of each Standard. These are found in the "how demonstrated" section that follows each Standard.
- Reflect legislative and regulatory changes affecting professional case management practice such as the need to include the client's family or caregiver in the provision of case management services and to the client's satisfaction.
- Replace the use of stigmatizing terms such as problems and issues with others that are empowering to the client such as

care needs and opportunities.

- Communicate the closure of professional case management services and the case manager-client relationship instead of termination of services and/or the case management process. This subtle change is better reflective of the reality that despite case closure, a client may continue to receive health care services however not in a case management context.
- Emphasize the provision of client-centered and culturally and linguistically appropriate case management services.
- Highlight the value of professional case management practice and the role of the professional case manager.
- Recognize the need for professional case managers to engage in scholarly activities, including research, evidence-based practice, performance improvement and innovation, and life-long learning.

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