THE CMSA STANDARDS OF PROFESSIONAL CASE MANAGEMENT PRACTICE

INTRODUCTION TO THE CMSA STANDARDS OF PRACTICE FOR CASE MANAGEMENT
Course Module Narrative

Introduction

The purpose of this multi-part module is to address the sections preceding the Standards within the Case Management Society of America (CMSA) Standard of Practice for Case Management.

Effective

Content for this module reflects the CMSA Standards of Practice, revised 2016.

Behavioral objectives

The behavioral objectives for this module are:

1. Define case management
2. Describe the relationship between Philosophy, Guiding Principles, and the Standards of Practice
3. List the components of the case management process

Contents

This module contains the following topics:

DEFINITION OF CASE MANAGEMENT

Purpose

This section addresses the **Definition of Case Management.**

Definition of case management

The focus of health care safety and quality cannot be overstated. There is no quality of care without first having a safe health care experience. CMSA modified its definition in recognition of the primary importance of promoting safe health care.

The CMSA definition of 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, p.11).

Importance of consistency in definition of case management

A definition is a formal statement of the meaning or significance regarding a word or phrase. It serves as a point of reference on which to educate and a framework upon which to base decisions, policies, or regulations. CMSA set an industry-wide standard definition of case management in 1993. The official CMSA definition was initially put forth following over a year of focused effort by members of the National Case Management Task Force. This is important because it is applicable to practice regardless of practice setting, educational background, credential, or area of specialization. This definition is used by accreditation organizations (e.g., National Committee of Quality Assurance, URAC). Since its initial appearance, the CMSA Board of Directors has continually assessed the definition to ensure it evolves and accurately reflects contemporary case management practice.

Association of definition and Standards of Practice

The delivery of case management involves the timely coordination of quality services to address a client's specific needs in a cost-effective manner in order to promote patient safety and positive outcomes (CMSA, 2016, p.11). The settings in which case management services are delivered have expanded over time. The activities considered part of the case management process, as well as the manner in which they are carried out, are performed within a consistent and principled framework. Both individual case managers, as well as case management departments, utilize the Standards of Practice to establish and maintain operational focused on delivery of high quality healthcare as a benefit to the client, caregiver, healthcare team, payer, and community.

As noted within the Evolution section, the current definition reflects the vibrant and dynamic progression of the standards of practice (CMSA, 2016, p.8). It is through this iterative, analytical process that CMSA's definition of case management continue to augment its credibility and relevance across the entire spectrum of the healthcare continuum.

PHILOSOPHY AND GUIDING PRINCIPLES

Purpose

This section addresses the **Philosophy and Guiding Principles.**

The CMSA philosophy of professional case management

It is important to define philosophy in the context of the Standards of Practice.

A philosophy is a statement of belief that sets forth principles to guide a program and the individual in his/her practice of that program (Tahan & Treiger, 2017). To that end, the CMSA Philosophy statement is:

The underlying premise of case management is based in 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 systems, the reimbursement source or payor, and other involved parties (CMSA, 2016, p.12).

The philosophy of case management underscores the recommendation that at-risk individuals, especially those with complex medical, behavioral, and/or psychosocial needs, be evaluated for case management intervention (CMSA, 2016, p.12).

Case management interventions focus on improving care coordination and reducing fragmentation of the services the recipients of care experience especially when multiple health care providers and different care settings are involved (CMSA, 2016, p.12).

Effective case management directly and positively impact the health care delivery system especially in realizing the goals of the "Triple Aim" which include improving the health outcomes of individuals and populations and enhancing the experience of health care (CMSA, 2016, p.12).

Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned.

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PHILOSOPHY AND GUIDING PRINCIPLES, Continued

What are the Guiding Principles?

The Guiding Principles (GPs) are relevant or meaningful concepts that clarify or guide practice. In professional case management practice, the GPs are:

- 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.
- Use a comprehensive, holistic, and compassionate approach to care delivery, which integrates a client's medical, behavioral, social, psychological, functional, and other needs.
- Practice cultural and linguistic sensitivity, and maintain current knowledge of diverse populations within their practice demographics.
- Implement evidence-based care guidelines in the care of clients, as available and applicable to the practice setting and/or client population served.
- Promote optimal client safety at the individual, organizational, and community level.
- Promote the integration of behavioral change science and principles throughout the case management process.
- Facilitate awareness of and connections with community supports and resources.
- Foster save and manageable navigation through the health care system to enhance the client's timely access to services and the achievement of successful outcomes.
- Pursue professional knowledge, practice excellence, and maintain competence in case management and health and human service delivery.
- Support systematic approaches to quality management, 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 application of case management standards of practice and relevant codes of ethics and professional conduct.

(CMSA, 2016, p.12)

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Connecting Guiding Principles to the Standards of Practice

This depiction illustrates just how interwoven the Principles are with the Standards. It is impossible not to conclude that the GPs serve as the firm framework on which the 2016 Standards of Practice are built.

Connecting Principles to Standards

Guiding Principles

1. Use a client-centric collaborative partnership approach
2. Whenever possible, facilitate self-determination and self care through the tenets of advocacy, shared decision-making and education
3. Use a comprehensive, holistic approach
4. Practice cultural competence, with awareness and respect for diversity
5. Promote the use of evidence-based care as available
6. Promote optimal client safety
7. Promote the integration of behavioral change science and principles
8. Link with community resources
9. Assist with navigating the health care system to achieve successful care, for example during transitions
10. Pursue Professional excellence and maintain competence in practice
11. Promote quality outcomes and measurement of those outcomes
12. Support and maintain compliance with federal, state, local, organizational, and certification rules and regulations

Guiding Principles	Standards of Practice
1	B, C, D, E, G, H
2	C, D, G, J
3	B, C, D, K
4	I, K
5	F, H
6	D, E, G
7	A, B, C, D, G
8	D, G, K
9	G, H, I, L
10	I, M, O
11	F, O
12	H, I, J, K

Standards of Practice

A. Client Selection Process for Professional Case Management Services
B. Client Assessment
C. Care Needs and Opportunities Identification
D. Planning
E. Monitoring
F. Outcomes
G. Closure of Professional Case Management Services
H. Facilitation, Coordination and Collaboration
I. Qualification for Professional Case Managers
J. Legal
K. Ethics
L. Advocacy
M. Cultural Competency
N. Resource management and stewardship
O. Professional Responsibilities and Scholarship

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Guiding Principles relevance to professional case management practice

The GPs are relevant and meaningful concepts that clarify or influence practice. Within the context of case management, the GPs drive practice towards its primary goals of improving patient wellness, stability, and autonomy within the foundational knowledge and skills set forth within the Standards of Practice (e.g., assessment, planning, advocacy, education, coordination, collaboration).

The GPs are applicable to all aspects of professional case management practice regardless of the setting in which it takes place. The case manager strives to uphold these values in all day-to-day interactions and activities. More importantly, the case manager projects these principles as integral to their professional identity.

The perception of case management is affected by every interaction in which a case manager takes part. A seemingly inconsequential conversation or action has the potential to make a significant impact on change in someone's perception of case management. In order to elevate the practice of professional case management, it is essential that all professional case managers achieve and maintain a principled practice.

CASE MANAGEMENT PRACTICE SETTINGS

Purpose

This section addresses **Case Management Practice Settings**.

Common practice settings

Case management practice spans the entire breadth of the healthcare delivery system continuum. This variety of settings includes, but is not limited to: institutions (e.g., acute hospital, rehabilitation hospital), payer (e.g., managed care organizations, private insurance), outpatient care (e.g., ambulatory clinics, community mental health centers), accountable care organizations, patient-centered medical homes, worker's compensation companies, independent case management organizations, government-sponsored programs (e.g., correctional facilities, military, Veteran's Administration), long term care services, end-of-life and respite care facilities, medical group practices, and population health management companies.

Complexity of case management service delivery

The practice varies in degrees of complexity, intensity, urgency and comprehensiveness based on the following four (4) factors. These are:

1. The context of the care setting, such as wellness and prevention, acute, subacute, and rehabilitative, skilled care or end-of-life.
   - An individual admitted to rehabilitation hospital for a spinal cord injury requires more complex and comprehensive case management plan of care than an independent and healthy person visiting an outpatient community clinic case manager.
2. The health conditions and needs of the client population(s) served, and the needs of the client's family or family caregivers, such as critical care, persistent and severe behavioral health condition, asthma, renal failure, hospice care.
   - An individual with multiple co-morbid conditions or serious injury requires more intense case management intervention than someone with a stable health condition.
3. The reimbursement method applied, such as managed care, workers' compensation, Medicare, or Medicaid. Worker's compensation and Medicaid coverage is state-specific and may involve a more rigorous bureaucratic burden be met than another payor.
4. The health care professional discipline of the designated case manager such as but not limited to a registered nurse, social worker, physician, rehabilitation counselor, and disability manager.

(Tahan & Treiger, 2017)

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CASE MANAGEMENT PRACTICE SETTINGS, Continued

Setting-specific impact to practice

Case management practice evolves based upon legislative and regulatory mandates. Influences are generated at both state and/or federal levels. Examples of impacts to case management include:

Setting	Considerations
Payer	The issue of job function rose in importance during the discussion and subsequent issuance with in the Federal Register of the Final Rule Medical Loss Ratio Requirements Under the Affordable Care Act (45 CFR 158 (2011). The final rule amends the regulations implementing the updated MLR standards for health insurance issuers under the Public Health Service Act in order to establish requirements for issuers in the group and individual markets that meet or exceed the applicable MLR standard. Payers must be mindful of the activities performed by case managers because of the manner in which the MLR is calculated to distinguish between direct healthcare and quality versus administrative cost of delivering health insurance benefits. The categorization of case management as a quality function means that it falls into the 80-85% of each premium dollar versus utilization management functions which are considered an administrative function and limited to only 15-20% of premium dollars.
Workers Compensation	State bureaus/departments of worker compensation develop requirements defining the qualifications and job requirements for case managers engaged in worker compensation programs. Each state has the legislative power to determine the provisions and requirements of its respective program and it is incumbent on the case manager to remain current of these program requirements.
Medicaid	According to the Centers for Medicare and Medicaid Services (CMS) Medicaid provides health coverage to nearly 60 million Americans. Federal law requires states to cover certain population groups and gives them the flexibility to cover other population groups. States set individual eligibility criteria within federal minimum standards and can apply for a waiver of federal law to expand health coverage beyond these groups (Medicaid.gov, n.d.). Because Medicaid is a combined federal and state funded program, regulations governing administration vary, "States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain mandatory benefits, and can choose to provide other optional benefits through the Medicaid program" (Medicaid.gov, n.d.). Case management is categorized as an optional benefit. Health plans bid for contracts to administer utilization management and/or case management services. Some states are moving toward a more hands-on practice of case management which includes mandatory face-to-face interaction with enrollees. The case manager considering work as a case manager within a Medicaid plan should understand the specific model and requirements of managing this population.

PROFESSIONAL CASE MANAGEMENT ROLES AND RESPONSIBILITIES

Purpose	This section addresses the **Case Management Roles, Functions, and Activities**.
What is a role?	In the Standards of Practice, the term role is defined as "a general, conceptual, or abstract term that refers to a set of behaviors associated with a position in a social structure, such as one's job title. It includes theoretical descriptions that guide one's expected behaviors. An example is case manager" (Tahan, Watson and Sminkey, 2015). Organizations and employers use a job title as an indicator of one's role; for example, acute care case manager.
What is a function?	The term function is defined as "a grouping of a set of specific tasks within the role" (Tahan, Watson and Sminkey, 2015).
What is an activity?	In the Standards of Practice, the term activity is defined as "a discrete action or task a person performs to meet the expectations of the role assumed. For example, an acute care case manager completes concurrent reviews with a payer-based case manager" (Tahan, Watson and Sminkey, 2015).

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Perspective on functions relating to role

A job description is an example of how different functions are organized under a specific role classification. In this instance, the functions are indicative of activities expected to be performed by the individual working in that job. A formal job description may contain more explanatory content for clarity's sake. Having a clear job description is essential in today's healthcare environment because of their relation to internal ratings, grades, and compensation. There is also the issue of job title misuse.

There are a number of reasons why the job title has been improperly used. Perhaps the most prevalent reason is that not all employers are aware of the official CMSA definition of case management, nor the Standards of Practice. Those who are aware may be restricted by organizational policies as to the preparation of job descriptions or the fact that the job description is being written with the priority given to reflect a specific organizational need rather than with a concept of professional case management practice. Recruiting clinical staff for open positions is a challenge with such a high demand for qualified staff. Using case manager as or within a job title is a way in which to attract attention to that vacancy.

Another influencing factor is that of continuous expansions and contractions within multi-step activities and health care settings. Over the years, legal, market, and regulatory changes forced departmental reorganization and subsequent job reclassifications. However, job titles were not consistently updated to reflect these shifts. In some cases, there was a purposeful decision not to change job titles. The rationale for this includes the belief that keeping an existing job title would lessen staff resistance to change as well as the desire to lessen bureaucratic requirements of re-grading and classification of positions. Hence, as an example, individuals taking on a utilization review function continued to be referred to as case managers (or care managers) despite the fact that they were no longer performing the scope of activities which encompass case management.

There are expanding job opportunities for professional case managers across the healthcare spectrum. This is reflective of the fact that the skill set development by professional case managers are transferrable across care settings. Though there are differences in job functions and activities, as new positions are created the respective jobs rely on conventional titles (e.g., case manager) or more creatively come up with branded job titles (e.g., nurse advocate, nurse guide) which align with organizational priorities rather than the CMSA Standards of Practice.

A professional case manager, as well as those functioning as or similar to a case manager (e.g., care coordinators, nurse advisors, clinical patient advocates), must closely evaluate the descriptions which applies to their position and advocate for appropriate changes that accurately reflect the job being performed. This works in the reverse as well. Position titles inclusive of the term case manager should be closely scrutinized to ensure that the job is actually inclusive of job functions, tasks, and responsibilities that reflect the Standards of Practice. If the position is not inclusive of these essential elements, it is recommended that the job title be changed. Unfortunately, there is no legal or regulatory recourse available to force such change.

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Skills and Knowledge

Successful care outcomes cannot be achieved without the specialized skills, knowledge, and competencies professional case managers apply throughout the case management process. Skills include, but are not limited to, motivational interviewing and positive relationship-building; effective written and verbal communication; negotiation and brokerage of services; cost-conscious allocation of resources; knowledge of contractual health insurance or risk arrangements; client activation, empowerment, and engagement; the ability to effect change, perform ongoing evaluation and critical analysis; and the skill to plan, organize, and manage competing priorities effectively.

To facilitate effective and competent performance, 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 relevant to case management practice. The skills and knowledge base of a professional case manager may be applied to individual clients such as in the hospital setting, or to groups of clients such as in disease, chronic care, or population health management models. Often case managers execute their responsibilities across settings, providers, over time, and beyond the boundaries of a single episode of care. They also employ the use of health and information technology and tools.

Roles and Functions of Case Management

The role functions of professional case managers may include, but are not limited to, the following:

- Considering predictive modeling, screening, and other data, where appropriate, in deciding whether a client would benefit from case management services.
- Conducting an assessment of the client's health, physical, functional, behavioral, psychological, and social needs, including health literacy status and deficits, self-management abilities and engagement in taking care of own health, availability of psychosocial support systems including family caregivers, and socioeconomic background. The assessment leads to the development and implementation of a client- specific case management plan of care in collaboration with the client and family or family caregiver, and other essential health care professionals.
- Identifying target care goals in collaboration with the client, client's family or family caregiver, and other members of the health care team. Securing client's agreement on the target goals and desired outcomes.
- Planning the care interventions and needed resources with the client, family or family caregiver, the primary care provider, other health care professionals, the payer, and the community-based agents, to maximize the client's health care responses, quality, safety, cost-effective outcomes, and optimal care experience.
- Facilitating communication and coordination among members of the interprofessional health care team, and involving the client in the decision-making process in order to minimize fragmentation in the services provided and prevent the risk for unsafe care and suboptimal outcomes.

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Professional Case Management Roles and Responsibilities, Continued

Roles and Functions of Case Management, continued

- Collaborating with other health care professionals and support service providers across care settings, levels of care, and professional disciplines, with special attention to safe transitions of care.
- Coordinating care interventions, referrals to specialty providers and community-based support services, consults, and resources across involved health providers and care settings.
- Communicating on an ongoing basis with the client, client's family or family caregiver, other involved health care professionals and support service providers, and assuring that all are well-informed and current on the case management plan of care and services.
- Educating the client, the family or family caregiver, and members of the interprofessional health care team about treatment options, community resources, health insurance benefits, psychosocial and financial concerns, and case management services, in order to make time
- Counseling and empowering the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.
- Completing indicated notifications for and pre-authorizations of services, medical necessity reviews, and concurrent or retrospective communications, based on payer's requirements and utilization management procedures.
- Ensuring the appropriate allocation, use, and coordination of health care services and resources while striving to improve safety and quality of care, and maintain cost effectiveness on a case-by-case basis.
- Identifying barriers to care and client's engagement in own health; addressing these barriers to prevent suboptimal care outcomes.
- Assisting the client in the safe transitioning of care to the next most appropriate level, setting, and/or provider.
- Striving to promote client self-advocacy, independence, and self-determination, and the provision of client-centered and culturally-appropriate care.
- Advocating for both the client and the payer to facilitate positive outcomes for the client, the interprofessional health care team, and the payer. However, when a conflict arises, the needs of the client must be the number one priority.
- Evaluating the value and effectiveness of case management plans of care, resource allocation, and service provision while applying outcomes measures reflective organizational policies and expectations, accreditation standards, and regulatory requirements.
- Engaging in performance improvement activities with the goal of improving client's access to timely care and services, and enhancing the achievement of target goals and desired outcomes.

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Accreditation considerations

Accreditation organizations such as The Joint Commission (TJC), National Committee for Quality Assurance (NCQA), and URAC provide specific standards for case management programs. In those standards are highlighted the qualifications, roles, functions and services deemed appropriate for achieving company or program accreditation. It is the responsibility of the professional case manager to remain informed of case management provisions when working with employers attempting to meet or retain accredited recognition.

As the industry transforms with new models of care including Accountable Care Organization, Patient Center Medical Homes, and Clinically Integrated Networks, additional standards and setting-specific consideration are developed. The knowledgeable case manager maintains awareness of setting-specific changes and considers how new delivery models may affect his/her practice. A proactive approach to enhanced understanding of these changes, as well as the acquisition of new knowledge, skills and possibly credentials is a key distinguisher for the professional case manager.

COMPONENTS OF THE CASE MANAGEMENT PROCESS

Purpose

This section addresses the **Components of the Case Management Process.**

The intellectual versus the administrative

Case management is an inter-disciplinary practice focused on the coordination of care activities and interventions and the allocation of resources required by a client during an acute or non-acute episode of illness or health care encounter (Tahan & Treiger, 2017). It is especially applicable for individuals with complex bio-psycho-social circumstances. It is carried out within the ethical and legal realms of a case manager's scope of practice, using critical thinking and evidence-based knowledge (CMSA, 2016, p.18).

Case management is a cyclical set of steps applied by case managers in their approach to patient care management. It is similar to processes applied by nurses, social workers, and other clinical professionals in approach to their respective particular practice. Case management requiring the practitioner have a solid foundation of clinical and business knowledge, as well as an understanding of

- reimbursement systems
- benefit coverage,
- active listening and motivational interviewing,
- legal and regulatory issues,
- organizational policies and procedures,
- licensure and certification requirements, and
- finely honed skills and competencies required to navigate the healthcare system on behalf of a client.

The relationship of these factors leads to the conclusion that a professional case manager must be a clinical professional who is qualified to work independently, yet collaboratively, in order to facilitate the client's complex needs. When the care system allows, this is optimally accomplished in an integrated manner that incorporates biological, psychological, social, and system-wide considerations. Qualifications are discussed in detailed within Module I – Qualifications for Professional Case Management.

There appears to be a trend within the healthcare industry that is premised on the belief that CM can be reduced to binary assessment questions, checkboxes, and automated interventions within a software program. These tools may bring efficiency to administrative tasks but they do not replace the professional case manager's approach to the CM process as an intellectual and analytical endeavor. Technology resources are a tremendous value-add but software is not the CM process, it is a tool that case managers use to document their work process not the process in and of itself (Treiger, 2012).

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Primary elements 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 iterative, rather than linear and unidirectional. For example, key 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 family caregiver, and other members of the interprofessional health care team.

The CM process is a systematic approach to client care delivery and management. It identifies what the case manager should do, how much, and at what frequency during the engagement. The Standards of Practice identify six (6) primary steps in the CM process (2016, p.18). The steps do not necessarily occur in a linear progression (Tahan & Treiger, 2017).

Applying the process requires the case manager to leverage critical thinking skills and evidence-based knowledge. The process extends beyond a specific professional identity (e.g., nursing, social work). The process relies upon strength of skills and knowledge attained during an individual's education and through training and experience. The CM process, as defined in the Standards of Practice consists of the following:

- Client Identification, Selection, and Engagement in Professional CM
- Assessment and Opportunity Identification
- Development of the CM Plan of Care
- Implementation and Coordination of the CM Plan of Care
- Monitoring and Evaluation of the CM Plan of Care
- Closure of the Professional CM Services

(CMSA, 2016, p.18)

There is a slight distinction in the CM process as it appears in the most recent CMSA Core Curriculum. The text identifies seven (7) elements of the CM process which include:

- Client identification/selection
- Assessment and problem identification
- Development of the CM plan
- Implementation and coordination of care activities
- Evaluation of the CM plan and follow-up
- Termination of the CM process
- Follow-up post-discharge or transition

(Tahan & Treiger, 2017)

The variance is a minute distinction and does not reflect a difference in the overall activities performed as a part of the CM process. It is important to remember that while the term *step* is used it is not an indication that the process or activities are performed in a linear progression. The CM process is continuous and cyclical as determined by the client's needs. It is also important to note that although a standard may be associated with a specific process step by virtue of its title, the CM process is iterative and all standards are taken into consideration throughout the engagement of professional CM services.

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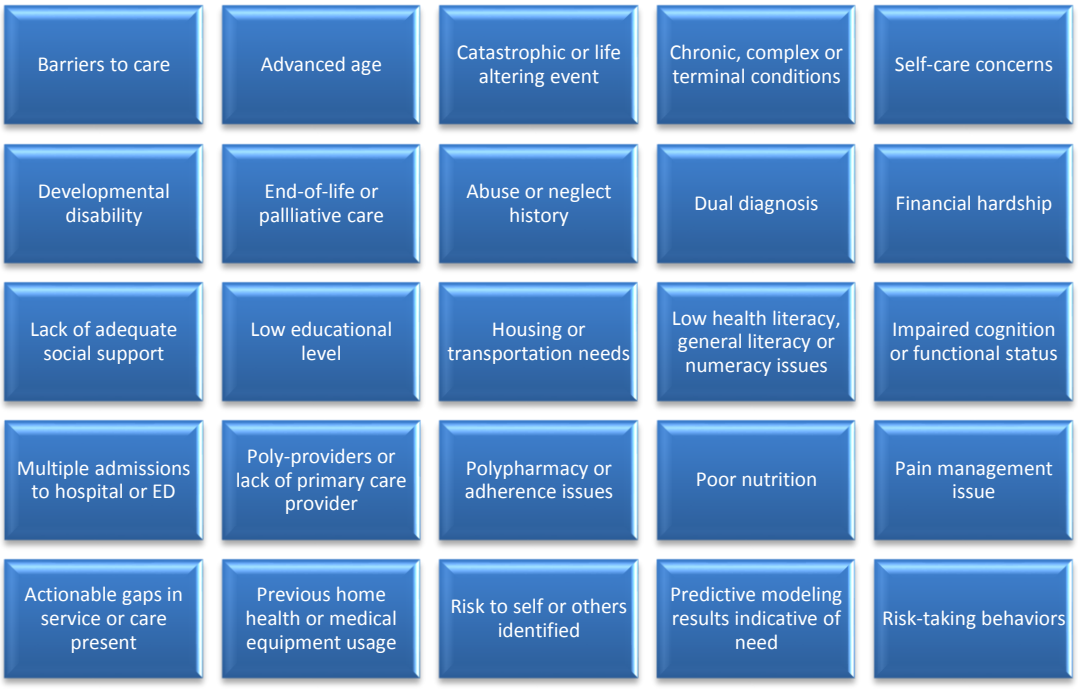
Client Identification, Selection, and Engagement in professional case management

This first step of the CM process is Client Identification, Selection, and Engagement In Professional CM. The desired outcome of this step is to identify individuals who may best benefit from working with a case manager.

In some organizations, this is the first step in the CM process whereas in others it is moot because a contractual or regulatory requirement exists (e.g., Medicaid, worker's compensation). This step is important to consistently and objectively determine which individual is apt to reap the most benefit from CM services and is often influenced by what is important to that organization (e.g., mission statement, department priorities) (Tahan & Treiger, 2017).

Risk factors used to identify clients for CM include, but are not limited to:



(CMSA, 2016, p.18; Tahan & Treiger, 2017)

Excluding individuals from case management is as important as determining those who are in most need of it. For instance, when an individual meets the applied criteria for level of care, has no transition needs, and has no barriers to healthcare services the impact realized from case management intervention is negligible and would not be indicated unless a risk issue arose which changed the individual's circumstances.

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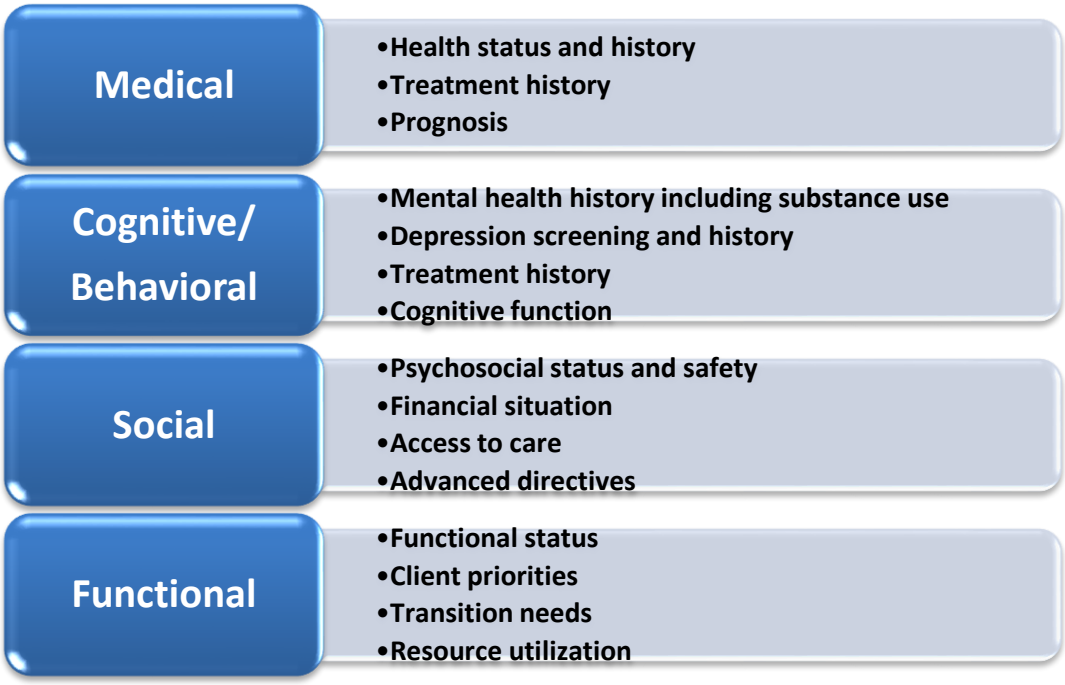
Assessment and Opportunity Identification

This step includes activities taking place following screening and selection for CM intervention. Tools associated with today's CM assessments vary from traditional hard copy forms to advanced software, which presents individualized assessment questions based on client responses. Most software automatically produces the client's list of opportunities, as well as a menu of possible interventions for the case manager to consider.

When working with advanced CM software, the professional case manager thoughtfully analyzes the product of automation and modifies the CM plan of care to reflect each client's situational needs. It is incumbent on the case manager to understand that software and related technology is a tool intended to make the workflow process more efficient but ultimately it does not take the place of critical thinking or the application of informed clinical judgment.

The case manager's skill and experience greatly affect that quality and amount of information obtained from the client as well as from other members of the care team, family and caregivers. Use of a conversational approach is less rigid than rote recitation of questions demanding narrow responses of yes or no, or one option selected from set of multiple choice. Experience builds case manager confidence to move seamlessly across all sections of an assessment tool using client cues which subsequently direct the order in which topics are address without losing control of the interaction. The case manager remains mindful of time constraints and attention span in an effort to demonstrate respect the individual and to conclude the conversation at a point easily resumed at later time.

Common sections in a case management assessment include, but are not limited to:



(CMSA, 2016, p.18)

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Development of the CM plan of care

In developing a case management plan of care, the professional case manager works collaboratively with the client, family caregiver, and care team to identify problems/opportunities, prioritize the order in of acuity, create useful and efficient interventions to address each, and to set realistic and achievable goals and outcomes (CMSA, 2016, p.18).

When a case manager delivers a fully formed CM plan of care to a client and/or other members of the care team without having given each the opportunity to provide input into its development, it is usually not well-received. A collaborative approach and cooperation with the anticipated interventions are more likely to occur when each stakeholder has a vested interest in the identification of opportunities and interventions to be applied in order to address them.

The case manager uses critical thinking and his/her understanding of client-specific circumstances to identify a range of interventions, services, and products required to implement the CM plan of care, incorporating all of the known resources that are available to the client (CMSA, 2016, p.18). Because no one person can possibly know everything there is to know, the case manager utilizes the tremendous opportunity available to incorporate the expertise of all care team members in creating the client's CM plan of care.

While resolving each and every client opportunity is an admirable objective, it is not necessarily achievable within the constraints of healthcare's busy environment or within a client's capacity or resources. To that point, the case manager must develop goals that are within the client's reach. This is another reason why the client and care team members must be involved throughout the CM plan of care development and engagement. Goals should be worded in a way that is objective and measurable.

Use of interim goals is essential to the development of what a client considers an achievable CM plan of care. For instance, Casey is a case manager working with an individual who was seriously injured at work after falling thirty (30) feet from a roof when the safety rigging failed. In addition to a multiple rib fractures causing a collapsed lung, he suffered a fractured femur, pelvis, and head injury. In light of these injuries, creating a CM plan of care item associated with mobility impairment is appropriate. However, specifying a goal such as "The client will return to full function and be able to resume his previous work within six (6) months", is unreasonable. This type of goal setting often contributes to unrealistic client expectations and leads to disappointment when progress in achieving the goal is deemed to be slow. This also ignores the influence of having achievable interim goals as a motivational tool during what is likely to be a prolonged recovery period.

The prudent case manager opts to set short-term goals, within the client's known abilities and works closely with the care team to identify opportunities for modifying the CM plan of care as functional abilities returns. In addition to the short-term goal(s), the case manager might want to suggest setting a stretch goal that seems to be just beyond of the client's current ability as another means of demonstrating improvement. Eventually, what appeared to be outside of the client's ability becomes an achievable outcome.

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Elements of a CM plan of care

The CM plan of care is a structured, dynamic tool used to document the opportunities, interventions, and expected goals the case manager applies during the CM engagement. The CM plan of care includes:

- Identified care needs, barriers, and opportunities for collaboration with the client and care team
- Prioritized goals and/or outcomes to be achieved
- Interventions or actions necessary to reach the agreed upon goals and/or outcomes.

(CMSA, 2016, p.18)

CM plan of care as a customizable tool

With consideration to the wide variety of case management information technology options available currently on the market, it is essential that the case manager has a tool that enables customization and modification of the CM plan of care to meet the client's needs while still providing a useful framework for consistent reporting of progress toward goals and outcomes achievement.

For instance, in the previous example three months into the case management engagement Casey realizes that her client is experiencing increasing levels frustration and anger. His wife describes how he is yelling a lot, which is new behavior since his injury. He refuses anyone's assistance regardless of how much difficulty he has performing a task. She shares "He would rather stew in his own juices than let someone do anything for him" and voiced increasing anxiety in connection with a recent incident which left him embarrassed and more angry. She describes having to call emergency services to help him off the bathroom floor, "I do not know how much more of this I can take and the kids are afraid to go near him when he starts ranting."

After assessing the situation and conferring with other care team members, Casey incorporates behavioral health interventions into the CM plan of care, including individual and family counseling. She also sets up another home assessment to ensure the appropriate equipment is in place for safe, efficient movement about the home. She works with the insurance company, physical therapist, and occupational therapist to ensure necessary equipment and devices are available and installed in the home promptly. Finally, Casey works with the client to set new goals that recognize and accommodate recent developments. It is at this point that the client verbalizes he felt the need to push himself to meet the goals he initially agreed to in order to get back to work as soon as possible. Casey realizes that by omitting interim targets, it placed an undue amount of pressure on the client. She also discovered that he mistakenly believed he "had" to meet the goals in order to continue receiving benefits.

Through communication and collaboration, Casey identified issues the client was facing and took action to address the issues. These activities touched on a number of practice standards as part of carrying out the CM process.

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COMPONENTS OF THE CASE MANAGEMENT PROCESS, Continued

Implementation and Coordination of the CM Plan of Care

The CM plan of care takes words into action through facilitated coordination of care, services, resources, and health education as specified in the plan. In order to execute an effective plan, there must be ongoing, bi-directional communication with the client, family caregiver, and other care team members (CMSA, 2016, p.19).

Monitoring and Evaluation of the CM Plan of Care

Documenting the CM plan of care's effectiveness is not an activity reserved for the end of a case management engagement. It is undertaken as a concurrent activity throughout the engagement of professional CM services.

Points of monitoring and evaluation include, but are not limited to:

- Ongoing follow-up with the client, family caregiver
- Evaluation of client status, progress toward goals and outcomes
- Monitoring activities which impact client progress
- Evaluating reasonableness of goals and interventions
- Identifying when modification of the CM plan of care is necessary and implementing those changes in a timely manner

(CMSA, 2016, p.19)

Continuous and ongoing monitoring of the client enables the professional case manager to devise and assimilate new interventions. The modified CM plan of care may turn out to have the more desirable impact on client progress and overall recovery. For instance, Casey learns that the transportation usually available to her client is not available during for an appointment next week. She assists the family to find alternate arrangements, the client keeps his upcoming orthopedic and physical therapy appointments.

Closure of the Professional CM Services

This step focuses on working with the client and family caregiver to formally disengage from active case management to a less intense intervention. A well-managed disengagement brings mutually agreed upon closure to the client-case manager relationship as well as the formal CM engagement. Case closure focuses on the discontinuation of professional CM services at a time when the client has attained the optimal level of function and recovery, the best possible outcome or the needs and desires of the client have changed (CMSA, 2016, p.19).

Whenever possible, closure of the CM engagement should be framed as a positive event. While certain circumstances for terminating service are less than ideal (e.g., loss of healthcare benefit, client death), the professional case manager approaches each client recognizing that at some time in the future, case management services or their involvement with the client will be terminated. This step of the CM process is a critical one for every professional case manager to master.

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COMPONENTS OF THE CASE MANAGEMENT PROCESS, Continued

Closure of Professional CM Services, cont.

Optimally, the topic of CM service closure begins at the point of introduction. Consistency in documenting interventions, observations, interactions, and outcomes provides evidence of progress toward goals. As accomplishments gradually grow, the topic of termination should be a natural part of dialog between care team members including the client and caregiver. Perhaps the least effective way in which to address termination is by addressing the topic only weeks before the anticipated termination date. Instead, recognizing each accomplishment, building the client's confidence level, and growing enthusiasm across the care team serves a useful purpose for smoothly withdrawing case management activity and transitioning the client to a less intense level of intervention.

In the recurring case example in this module, Casey experienced challenges throughout the engagement but she continually works with the client to address the barriers to recovery. Although the client may not return to 100% of their pre-accident abilities, recovery was ultimately not measured against that outcome. Instead, Casey helped the client recognize that each forward step of progress is an event to celebrate. She framed transition to a less intense intervention of care coordination as tremendously meaningful in that he had improved to such a degree that he no longer required her constant, hands-on involvement in his care because he could do more for himself.

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