THE CMSA STANDARDS OF PROFESSIONAL CASE MANAGEMENT PRACTICE

RESOURCES MANAGEMENT AND STEWARDSHIP
Course Module Narrative

Purpose

This module addresses the Case Management Society of America (CMSA) Standard of Practice for Case Management: Resource Management and Stewardship.

Effective

Content for this module reflects the CMSA Standards of Practice for Case Management, revised 2010.

Behavioral Objectives

The behavioral objectives of this module are:

1. Understand the importance of managing resources to maintain cost-effective outcomes
2. Define the criteria used to assess quality, appropriateness and medical necessity of resources
3. Identify how the case manager can demonstrate his/her value to the healthcare system

Standard

Changes to the standard appear underlined.

- The professional case manager should integrate factors related to quality, safety, access, and cost-effectiveness in assessing, planning, implementing, monitoring, and evaluating health resources for client care (CMSA, 2016, p.29).

How demonstrated

Adherence to this Standard may be demonstrated as:

- Documented evaluation of safety, effectiveness, cost, and target outcomes when designing a CMP to promote the ongoing care needs of the client.
- Evidence of follow-through on the objectives of the CMP which are based on the ongoing care needs of the client and the competency, knowledge, and skills of the professional case manager.
- Application of evidence-based guidelines and practices, when appropriate, in recommending resource allocation and utilization options.
- Evidence of linking the client and family or family caregiver with cultural and linguistically appropriate resources to meet the needs and goals identified in the CMP.
- Documented communication with the client and family or family caregiver about the length of time for availability of a necessary resource, potential and actual financial responsibility associated with a resource, and the range of outcomes associated with resource utilization.
- Documented communication with the client and other interprofessional health care team members, especially during care transitions or when there is a significant change in the client's situation.
- Evidence of promoting the most effective and efficient use of health care services and financial resources
- Documentation which reflects that the intensity of CM services rendered corresponds with the needs of the client (CMSA, 2016, p.29)

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Balancing benefits and access

Many clients may have limited funding for certain healthcare needs such as mental health or inpatient rehabilitation. Balancing these needs within the provisions of the benefit plan or available resources may be challenging.

Once healthcare benefits and coverage (e.g., Medicaid, Medicare, commercial insurance) have been confirmed, case managers need to determine how to obtain the maximum value from the available benefit, dollars or resources, by utilizing such strategies as:

- Researching treatment and facility alternatives
- Negotiating price reductions
- Evaluating quality to price value as part of facility, service and equipment recommendations
- Shifting cost to allocate expense within appropriate benefit category
- Obtaining exceptions to benefits (e.g., reducing inpatient costs through utilization of home health services)
- Collaborating with prescribers of experimental procedures/treatments to assess potential harm versus benefit

Scenarios: Considering treatment and facility alternatives

The case manager evaluates each client's needs and facility alternatives in order to maximize available benefits. In the following examples, the fact pattern is altered in order to illustrate how variation can affect treatment choice:

Scenario 1	Donald Jones is a fifty-nine (59) year old male who is four (4) days status post cerebral vascular accident. Mr. Jones was employed full time at the time of his illness and otherwise healthy. He has been clinically stable for the past twenty-four (24) hours. The transition plan, with which the client's wife is in agreement, is to send Mr. Jones for intensive rehabilitation inclusive of physical, occupational, and speech therapies. It is anticipated that he will receive at least five (5) hours of therapy each day. Mr. Jones' benefit plan includes acute rehabilitation hospital coverage as well as one hundred (100) days of skilled nursing facility. Based upon his current and pre-morbid condition and the number of therapy hours per day, acute rehabilitation hospital admission is identified as the best use of available benefits.
Scenario 2	David Smith is an eighty-four (84) year old male who is ten (10) days status post cerebral vascular accident. Mr. Smith has been disabled for over twenty (20) years. He has a history of chronic obstructive pulmonary disease (COPD), diabetes mellitus and atrial fibrillation. He has been on long-term home oxygen therapy and his diabetes is somewhat controlled with insulin. The transition plan is to send Mr. Smith to a skilled nursing facility (SNF) in order to receive physical and occupational therapy. Due to COPD and his generally deconditioned physical state, it is anticipated that he will only tolerate two to three (2-3) hours of therapy six (6) days each week. Mr. Smith's benefit plan includes acute rehabilitation and ninety (90) SNF days. However, in order to meet acute rehabilitation level of care it is required that he participate in at least five (5) hours of therapy each day. Based on his current condition and the number of therapy hours per day, SNF placement is deemed the best use of available benefits.

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Resource Management and Stewardship, Continued

Resource allocation and utilization management

Stewardship is defined as "Responsible and fiscally thoughtful management of resources" (CMSA, 2016, p.36). The professional case manager often acts as a resource steward for their clients, fostering collaboration and developing strategies to achieve goals while overseeing and protecting the sometimes limited healthcare dollars available.

Utilization management is a function which may or may not be included within job functions of a case manager. Defined as the "review of services to ensure they are medically necessary; provided in the most appropriate care setting, and at or above quality standards" (Treiger & Tahan, 2017), this activity tends to be more of an administrative task using evidence-based guidelines to assess the appropriateness of care based on setting, intensity. Both resource allocation and utilization management provide the case manager with a context for initiating and continuing communication across the care team.

Financial responsibilities for resources utilized

The case manager continually evaluates the medical necessity, appropriateness, and efficiency of healthcare procedures, services, and facilities within the client's health plan benefits. When identifying goals to be achieved prices must also be included. Some healthcare plans require pre-authorization for certain interventions, limit dollars for specific interventions/treatments, or offer the option of requesting benefit exceptions.

Decision points regarding appropriateness and necessity may be dictated by a number of factors including corporate policy, department guidelines, and evidence-based decision support tools (e.g., InterQual®, Milliman®). The case manager is knowledgeable about the specific criteria being applied in making benefit determinations. The case manager should request a copy of the specific criteria, guideline, or policy in order to proactively provide documentation and facilitate the decision-making process.

One important goal of resource management is to achieve cost savings. The art of negotiation is an important aspect of a case manager's skills necessary within the current healthcare environment of declining/limited benefits and resources. Negotiating reduced or capped fees for services, durable medical equipment (DME), or inpatient per diem is crucial in controlling costs and optimizing benefits.

Benefit exceptions

Negotiating a benefit exception may be a viable option when the end result is anticipated to justify going outside a health plan's benefit structure. This is an example of creative advocacy. The skilled case manager thinks outside the box in order to support the client's needs. Although one's setting of practice impacts the way in which benefits exceptions are handled, there is usually an established process in place and/or forms which are required to be completed.

The case manager takes many factors into consideration in preparing a benefit exception proposal, including the following:

- Treating physician's recommendation/request
- Evidence available in support of option
- Anticipated benefit (e.g., cost savings, reduction in utilization)
- Cost of covered alternatives
- Impact on client (e.g., enhanced quality of life, improved functional ability)

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Benefit exceptions, *cont.*

In the worker's compensation field, a case manager may need to negotiate with the claims adjuster in order to obtain payment for something that is not generally considered compensable. However, if the injured worker will derive measurable benefit from the service/product, and the employer is amenable, the investment may actually reduce the overall cost and exposure of the claim.

Managed care case managers are often faced with the dilemma of working within a prescribed benefit structure that is also influenced by whether the plan is purchased directly by the consumer or by a company as part of their employee's benefit package. In addition, the company may carry a self-insured plan, which may or may not affect the flexibility with which benefit exceptions are granted.

Hospital-based case managers may find that although a client qualifies for post-acute placement in a SNF, the client's circumstance makes placement at a rehabilitation hospital a more effective solution. It is important to provide the payer with all of the pertinent facts in advocating for an authorization of higher level of care than may be immediately warranted.

Situations may arise in which pressure to grant an exception comes from outside usual communication channels (e.g., media coverage, legislator intervention). The case manager works in a collaborative manner with department management, Medical Director, account manager, treating provider, and other parties in order to efficiently address the request. These situations may not follow organizational policy and the professional case manager acts in an ethical manner in resolving the matter.

Balancing quality and safety

Matching the client's care needs to a particular treatment/care setting is not the only component in identifying appropriate placement or referral. Quality of care and customer service varies. Because of this, the one with the lowest cost may not be the most cost-effective option for your patients.

In the previous scenario, Mr. Smith's benefits included acute rehabilitation coverage however his overall condition would not have allowed him to fully participate in available therapies to the degree required to meet that level of care. The application of decision-making criteria to client status and available benefits lead to the decision that SNF level of care would appropriately meet the client's needs.

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Balancing quality and safety, cont.

Case managers assess the quality of the facility/service provider to ensure that the dollars are used wisely to facilitate optimal outcomes and recovery. Several approaches may be helpful as part of this assessment, including:

Accreditation	Examples of accreditation sources include The Joint Commission, the National Committee of Quality Assurance, and URAC. This would also include reviewing staff qualifications, staff/client ratio, turnover rate, and medical director qualifications.
Structure	Specific services and facilities available. Is there an internal quality control or risk management program?
Process	Was there a timely response to the request for services? Will the facility/provider allow the case manager to function as part of the team?
Care Guidelines	Does the facility utilize evidence-based guidelines (e.g., InterQual®, Milliman®) or disease state management guidelines when devising care and treatment protocols?
Client/Caregiver Satisfaction	Does a facility offer the results from formal client satisfaction surveys or former patients/caregiver testimonials? Is it possible to contact individuals to discuss satisfaction with the treatment/care provided in that setting?
Outcome Data	Is outcome data available from third party sources (e.g., Nursing Home Compare)? Accredited facilities should have data/statistics available on mortality, morbidity, return to work, health data and treatment plan goals achieved available upon request. Are these outcomes in line with other facilities that provide similar services?

Connecting resources to care plan goals and objectives

The key to successful CM is to thoroughly assess the relevant information pertaining to the client's care plan goals and objectives through communication with all members of the client's healthcare team. The case manager considers resources, as well as available benefits, during the development of the CMP, goals, and interventions.

The following questions are worthy of consideration throughout the engagement of CM services:

- Are goals and desired outcomes/objectives clearly defined and categorized as long, intermediate or short term?
- Was the client/caregiver involved in developing goals and outcomes/objectives?
- Do all members of the treatment team support of the current goals and outcomes/objectives?

As noted in previous modules, a CMP is developed to define the manner in which client goals and outcomes/objectives will be achieved. The CMP also provides a road map for tracking progress and achievement. Although case managers may use a different documentation format, CMP goals and objectives should be:

- **S**pecific
- **M**easurable
- **A**ttainable
- **R**elevant
- **T**ime-specific

The S.M.A.R.T. approach to planning and goal-setting is discussed in more detail in other modules.

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Assessing progress

Assessing the client's progress towards goals should be done on a regular basis to allow for modification should it become apparent that they are no longer realistic or achievable as initially anticipated. This is a critical step in order to ensure resources are being utilized appropriately according to the needs of the client.

Factors influencing modification of the CMP include client progress and the discovery of new information. The case manager maintains a flexible approach when working with a client/caregiver because healthcare and recovery from illness do not always follow a linear forward progression. It is up to the case manager to monitor progress towards outcomes in order to optimally allocate resources.

Objective assessment scales are often used to measure progress and outcomes. Examples of these tools include, but are not limited to:

Tool	Description
Functional Independence Measure (FIM)	The FIM scale assesses physical and cognitive disability. This scale focuses on the burden of care and disability, which can be indicative of the burden placed on the care team / caregiver. Understanding this contributes to appropriate resource identification and management.
Level of Rehabilitation Scale (LORS)	The LORS-III consists of seventeen (17) measurement areas that represent abilities in ADL, mobility, communication, cognition, and memory.
Children and Adolescent Functional Assessment Scale (CAFAS)	This scale is used with children and adolescents to assess day-to-day function across critical life activities and to determine whether a function improves over time.
Rancho Level of Cognitive Functioning Scale (LCFS)	The LCFS was developed to assess cognitive functioning in post-coma patients. It is used in the planning of treatment, tracking of recovery, and classifying of outcome levels. Leveraging this scale helps track progress, or lack thereof, and contributes to a comprehensive picture of the client's status and needs.
Functional Status Questionnaire	The FSQ is a standardized, self-assessment that will provide a comprehensive assessment of physical, psychological, social, and role functions for ambulatory patients. It can be used as an initial assessment and also as a measurement of progress and improvement.

Although tools and assessment scales are helpful they should not be relied upon as a sole source of grading the client's progress. Every tool has limitations and may not accurately reflect an individual's achievements nor accurately measure some goals. In addition, it is important to understand the knowledge and experience level of the individual utilizing these tools in order to ensure accurate application and interpretation. The professional case manager applies clinical judgment and objectively documents the facts to illustrate all aspects of the client's recovery.

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Connecting clients and resources for informed decision making

According to the Informed Medical Decisions Foundation, shared decision making is defined as "the process by which a health care provider communicates to the patient personalized information about the options, outcomes, probabilities, and scientific uncertainties of available treatment options and the patient communicates his/her values and the relative importance he/she places on benefits and harms" (2012).

The case manager encourages each client/caregiver to participate in the development of their treatment plan and healthcare goals. Initiating conversation about current healthcare issues, concerns, and treatments is one way in which to specifically engage in active discussion. For example, asking a client if he has any question is often too broad an approach. However, asking a client to explain their understanding of why they have been prescribed a specific medication, gives that person a very specific focus to start from.

Using this client-centric approach allows an opportunity to for the individual to talk about something from their own perspective. Gaps in understanding usually come to light quickly and can be specifically addressed within the client's context of understanding. Everyone benefits when patients and caregivers are informed as to healthcare status and participate in care management and treatment decisions. The case manager will identify gaps in knowledge, as well as available resources, in order to ensure the client/caregiver is making informed treatment decisions.

Resources to support the client/caregiver in the decision-making process are noted in the Resources section at the end of this module.

Managing client expectations

Clients and their caregivers are important members of the treatment team and will have their own goals and expectations. The case manager needs to ensure that the service provider is aware of these goals, that they are reasonable given the client's health/medical needs and that they are taken into consideration during the development of the treatment plan.

The case manager works closely with the client and caregiver in order to establish realistic and achievable goals. There are situations in which the client sets unrealistic goals. There are many reasons for this but most often it is related to a lack of understanding about their health condition or related to denial regarding their overall prognosis. The case manager is empathetic in conversations which focus on health condition and prognosis and communicates the client's current beliefs with other care team members, especially the treating provider, in order to develop an approach strategy and/or re-education process.

When an unrealistic client goal involves a specific skill, a strategy which may be leveraged involves setting up a safe practice session. If it is the consensus of care team, the client and/or caregiver is given an opportunity to practice (or attempt) the activity within a controlled setting to ensure safety. Through this exercise, the client/caregiver is faced with the reality of their disability and may then realize their desired goal is not currently realistic. With the physical and emotional support of their care team, the client/caregiver may then be able to revise their goal to one that can be achieved through the treatment plan.

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Cost/benefit analysis

Cost should not drive practice; however in a world that is cost-contained oriented, case managers must be aware that their services must provide a benefit and they must be able to demonstrate this benefit (Tahan & Treiger, 2017).

Case managers use cost-benefit analysis to demonstrate value to the healthcare system. Documentation of savings achieved through the implementation of a service, use of a product or as a result of CM interventions is an important outcome that can be accessed through a variety of measures. When documenting savings, the cost-benefit analysis includes an overview and summary of the CM interventions as well as the cost associated with these interventions. Savings achieved may be captured in the following ways:

- Negotiated or discounted rates for service or cost
- Avoided costs (e.g., duplicate treatment, surgery, avoided admission, reduced length of stay)
- Early return to work or avoiding lost time
- Reduced medication costs
- Gross savings (potential costs minus actual charges)
- Net savings (gross savings minus CM expense)

The summary of the cost-benefit analysis outlines case manager-specific interventions (e.g., enhancement of care quality, achieved outcomes, injury prevention) and highlights appropriate resource utilization in support of savings achieved through CM services. Though not every case will demonstrate cost savings, the goals achieved through CM intervention demonstrate the benefits derived by the client that would not have otherwise occurred.

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Durable Medical Equipment: Finding Value

Finding good value in procuring a piece of DME is a frequent CM challenge. Variables affecting decision-making include: purpose of the equipment, function, limitations of the client's home to accommodate certain features, impact anticipated in quality of life, and the client's comfort not only as a result of having the equipment, but also with its safe operation. Most DME vendors offer similar, if not the same, equipment.

Consider the following when making a decision/recommendation to the client/caregiver.

Question	Considerations
Does the insurance company have a contracted agreement with a particular supplier/vendor?	Contractual obligation may limit the case manager's choice of vendor. Apply due diligence and check competitor pricing. If lower pricing is available, inform the insurance company and use the information to negotiate a lower price with the contracted vendor.
Does only one provider carry a specific piece of equipment?	Supplier/Vendor options may not exist for a particular piece of equipment. This may be a result of the geographic area where the DME is needed or the specific nature of the DME itself. Negotiate with the supplier/vendor on issues other than price point, such as: • Ask for a discount in return for prompt payment terms • Ask for the Medicare rate rather than the usual and customary charge

Always keep in mind that there is no harm in simply asking if a vendor can provide a piece of equipment on terms more favorable to the client (e.g., cost, payment terms). While not always possible, it is not infrequent that the supplier/vendor will do so. It is important to determine if there are any restrictions on individual negotiation prior to proceeding with this course of action. Some payer sources may not allow their employees to participate in this practice.

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Allocating case management time appropriately

Controlling the costs of CM is a major factor in promoting the value of such, yet there is an obligation to assist the client that may go beyond advocacy. The case manager needs to assess whether to use their time and associated costs to research community resources to meet the client's needs or leave it up to the client to fund these needs out of pocket or go without.

The client and caregiver participation and involvement in their treatment plan is a key component in their healthcare. The case manager's assessment of the utilization of their time to best meet certain client needs that will promote wellbeing and avoid exacerbating medical conditions is essential. Identifying local and national resources that can assist in this process and work directly with the client and caregiver allows the case manager to minimize duplication of services where another agency can provide their expertise.

In some cases, CM services can offer more support at a later time in the client's treatment when their condition is likely to deteriorate or when the care required will become more complex and the need to coordinate additional services arises. The case manager needs to assess the frequency and type of contact needed with the client in order to avoid driving up costs unnecessarily. Depending on the delivery model or organization, the case manager may want to recommend maintaining telephonic contact rather than on site visits with their patients or decrease the frequency of contact to semimonthly, monthly or bi monthly. These changes will facilitate continued effective communication, management of the situation and the client relationship until complications occur or the need for services changes.

Module questions

1. The professional case manager should integrate factors related to quality, safety, access, and cost-effectiveness in assessing, monitoring, and evaluating health resources for client care. True / False

2. The professional case manager takes many factors into consideration in preparing a benefit exception proposal. Which of the following would <u>not</u> be a consideration?
   A. Anticipated benefit (e.g., cost savings, reduction in utilization)
   B. Cost of covered alternatives
   C. Impact on client (e.g., enhanced quality of life, improved functional ability)
   D. Referring physician's opinion
   E. Treating physician's recommendation/request

3. The professional case manager often acts as a resource steward for their clients and utilization management is one aspect of resource stewardship. True / False

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Informed Medical Decisions Foundation (2012). *What is shared decision making?* Retrieved August 31, 2016 http://informedmedicaldecisions.org/what-is-shared-decision-making.

Tahan, H.M. and Treiger, T.M. (Eds.) (2017). *CMSA core curriculum for case management*. (3rd ed.). Philadelphia, PA: Wolters Kluwer.

Additional resources

Children and Adolescents Functional Assessment Scale (CAFAS)
http://www.fasoutcomes.com/Content.aspx?ContentID=12

Functional Independence Measure (FIM)
http://www.rehabmeasures.org/Lists/RehabMeasures/DispForm.aspx?ID=889

Home Health Compare
http://www.medicare.gov/HomeHealthCompare/search.aspx

Hospital Compare
http://www.hospitalcompare.hhs.gov/

Nursing Home Compare
http://www.medicare.gov/NHCompare

Preschool and Early Childhood Functional Assessment Scale (PECFAS)
http://www.fasoutcomes.com/Content.aspx?ContentID=13

Rehabilitation Institute of Chicago Function Assessment Scale, version 5 (RICFAS)
http://lifecenter.ric.org/index.php?tray=content&tid=top1&cid=1960