



# Standards of Practice for Case Management



The Evolution of the Standards

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The Definition of Case Management

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Philosophy and Guiding Principles

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Case Management Practice Settings

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Components of the Process

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Standards of Case Management

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Acknowledgements and Glossary

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# Standards of Practice for Case Management, Revised 2010<sup>©</sup>

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# Foreword

It is our pleasure to present the 2010 revision of the Case Management Society of America's (CMSA) *Standards of Practice for Case Management (SoP)*. These Standards were first published in 1995 and revised in 2002. Today, as our nation faces ever-changing challenges to our health care system, CMSA recognized the need to revise the *Standards of Practice* to be more reflective of the rapidly growing and expanding role of case managers and the increased awareness of case managers as crucial members of the health care team. These key issues, among others, provided the impetus to re-examine and redefine our role in the current health care matrix.

As our profile becomes ever more visible, it is critical that we examine ourselves and set standards by which we must be held accountable. Among the many changes to this edition, one of special note is the revised qualifications language. To establish our position as providers of service and to improve our position for reimbursement of case management services, it is imperative to establish accepted qualifications for case managers. Equally important, it is essential to validate our positive outcomes as we work with patients through case management interventions. Ultimately, by clarifying our qualifications and validating outcomes achieved, the *Standards of Practice* will strengthen the case management professional.

This edition of the *Standards of Practice* is the product of many hours of labor, research, and deliberation among those who served on the task force, reference committees, case managers at-large, and the CMSA Board of Directors, who ultimately approves the *Standards of Practice*. There are many people to thank for their role in this revision. First, we must acknowledge Peter Moran who had the wisdom to call for the revision during his presidency and the foresight to ask Carrie Marion to lead the task force. We would also like to recognize the efforts of Cheri Lattimer and Danielle Marshall who have shepherded and supported the project over the past two years.

Lastly, we would like to thank you, the case managers, for providing service to those in need, and for being part of "what is right" in health care through your passion and commitment.

The time from conception to fruition of this edition of our *Standards of Practice* has spanned three CMSA presidencies, and we are grateful to have been part of this historic moment-in-time for case managers and CMSA.

*Jeff Frater, RN, BSN, CMSA President (2008 – 2009)*

*Margaret "Peggy" Leonard, MS, RN-BC, FNP, CMSA President (2009 – 2010)*

# Preface

The *Standards of Practice for Case Management* were first introduced by the CMSA in 1995 and then revised in 2002. We are pleased to offer the *Standards of Practice for Case Management*, 2010 revision, which provides voluntary practice guidelines for the case management industry. The *Standards of Practice* are intended to identify and address important foundational knowledge and skills of the case manager within a spectrum of case management practice settings and specialties.

The 2010 Standards reflect many changes in the industry, which resonate with current practice today. Some of these changes include the following:

Minimizing fragmentation in the health care system, using evidence-based guidelines in practice, navigating transitions of care, incorporating adherence guidelines and other standardized practice tools, expanding the interdisciplinary team in planning care for individuals, and improving patient safety.

We believe that these are all important factors that case managers need to address in their practices. The 2010 *Standards of Practice* contain information about case management practice, including definition, practice settings, roles, functions, activities, case management process, philosophy and guiding principles, as well as the standards and how they are demonstrated. This document is intended for voluntary use and is not intended to replace relevant legal or professional practice requirements.

The 2010 *Standards of Practice* were developed through the efforts of dedicated case managers who spent countless hours synthesizing information over two public comment periods to develop this document.

The teams include:

- (1) A core task force made up of representatives of the case management field in various practice settings and disciplines
- (2) A larger reference group that included the CMSA leadership and Board of Directors, legal advisors, and the case management industry
- (3) Other case management experts in the industry
- (4) Case managers at-large during the Public Comment period

It has been my pleasure to work on this project with the talented and committed individuals who are raising the bar of excellence in the field of case management.

*Carrie Marion, RN, BSN, CCM*  
*Committee Chair*

# I. Introduction

The consistent delivery of quality health care services and the high financial cost generally associated with those services are important concerns that touch everyone, from our leaders in Washington, D.C. to the American public. *Payers* continue to seek methods for reducing costs while advancing quality and transparency. *Providers* explore methods to define and report quality while maximizing reimbursement. Too frequently, the health care *consumer* is left to navigate the health care system without the tools, resources, support or education that are vital to this role.

Although a number of strategies for health care reform have been espoused and debated, case management has emerged as an important intervention that fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on quality of care and client self-determination.

Founded in 1990, the CMSA is the leading non-profit association dedicated to the support and development of case management. The strategic *Vision* of CMSA approved in 2009 is as follows:

**Case managers are recognized experts and vital participants in the care coordination team who empower people to understand and access quality, efficient health care.**

To complement this *Vision*, case management practitioners, educators and leaders have come together to reach consensus regarding the guiding principles and fundamental spirit of the practice of case management. As initially presented and with each subsequent revision, the *Standards of Practice for Case Management* have been based on an understanding that case management is not a specific health care profession, but rather an advanced practice within the varied health

care professions that serves as a foundation for case management. Therefore, the Standards described within this document are not intended to be a structured recipe for the delivery of case management interventions. Rather, they are offered to present a range of core functions, roles, responsibilities, and relationships that are integral to the practice of case management.

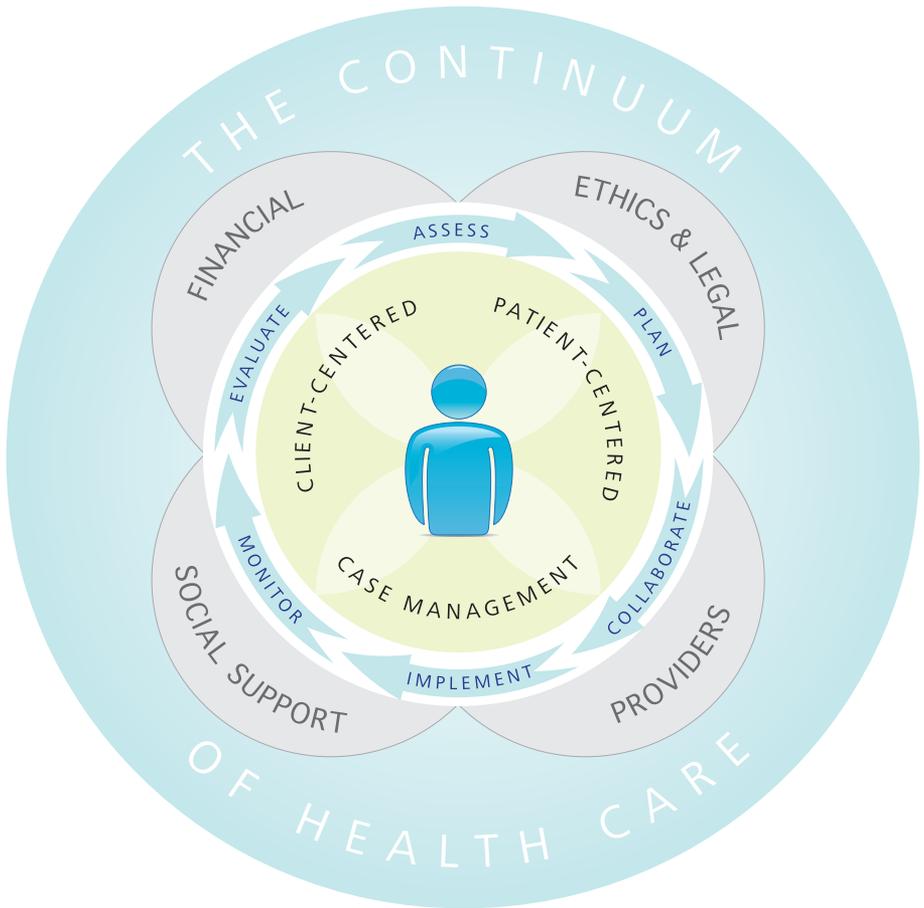
The nature of the written word has limitations, and definitions used in the Standards required much discussion. With the exception of the Continuum of Health Care figure (See page 5) where two terms (client and patient) are reflected, *the word "client" is used throughout these Standards to mean the recipient of case management services.* This individual may be a patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care consumer of any age group. However, "client" can also mean something very different than the end-user of case management services; a client can also imply the business relationship with a company who contracts, or pays, for case management services.

To further define the recipients of case management interventions, the term "*support system*" is used. This *support system* is defined by each client and may include biological relatives, spouses, partners, friends, neighbors, colleagues, or any individual who *supports* the client. Note that sometimes when using the term "client," it may also be inclusive of the client's support system.

Another decision made was use of *case management*, rather than *care management*. These two terms are further defined in the Glossary, but for consistency, case management is used throughout this document.

Some adjustments may be necessary as these Standards are incorporated into

## The Continuum of Health Care



individual practices. For example, where these Standards used the word “client,” you may choose to substitute *resident, consumer, beneficiary, individual*, or another term.

While the Standards are offered to standardize the process of case management, they are also intended to be realistically attainable by individuals who use appropri-

ate and professional judgment regarding the delivery of case management services to targeted client populations.

Additionally, the Standards may serve to present a portrait of the scope of case management practice to our colleagues and to the health care consumers that work in partnership with the case management professional.

## II. Evolution of the Standards of Practice for Case Management

### A. 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 would utilize 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, 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 legal requirements.

Even at this first juncture, the Standards committee recognized the importance of the case managers basing their individual practice on valid research findings and they encouraged case managers to participate in the research process, programs, and development of specific tools for the practice of case management. This was evidenced by key sections that highlighted measurement criteria in

the collaborative, ethical, and legal sections (CMSA, 1995).

### B. Standards of Practice for Case Management (2002)

The 2001 Board of Directors for CMSA identified the need for a careful and thorough review and, if appropriate, revision of the initial published Standards. The revised *Standards of Practice for Case Management* were published in 2002. The published definition of case management was amended to (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 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 appropriate access to care.

Primary case management functions in 2002 included both current and new skills and concepts: positive relationship-building; effective written/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; promote client autonomy and self-determination; and knowledge of funding sources, health care services, human behavior dynamics, health care delivery and financing systems, and clinical standards and outcomes.

Case management work applied to individual clients or to groups of clients, such as in disease management or population health models. The facilitation section 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 worked.

### **C. Standards of Practice for Case Management (2010)**

The *Standards of Practice for Case Management* 2010 include topics that influence the practice of case management in the current health care environment. Included in this revision are:

- Addressing the total individual, inclusive of medical, psychosocial, behavioral, and spiritual needs.
  - Collaborating efforts that focus 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 available, in the daily practice of case management.
  - Focusing on transitions of care, which includes a complete transfer to the next care setting provider that is effective, safe, timely, and complete.
- Improving outcomes by utilizing 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, including 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.

These changes advance case management credibility and complement the current trends and changes in health care. Future case management *Standards of Practice* will likely reflect the existing climate of health care and build upon the evidence-based guidelines that are proven successful in the coming years.

### III. Definition of Case Management

The basic concept 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 positive outcomes. This can occur in a single health care setting or during the client's transitions of care throughout the care continuum. The case manager serves as an important facilitator among the client, family or caregiver, the health team, the payer, and the community.

As demonstrated in the section on the *Evolution of the Standards of Case Management*, the definition of case management has evolved over a period of time; it reflects the vibrant and dynamic progression of the standards of practice.

Following more than a year of study and discussion with members of the National Case Management Task Force, the CMSA's Board of Directors approved a definition of case management in 1993.

Since that time, the CMSA Board of Directors has repeatedly reviewed and analyzed the definition of case management to ensure its continued application in a dynamic health environment. The definition was modified in 2002 to reflect the process of case management outlined within the Standards. The definition was again revisited in 2009 and modified to further align with the current practice of case management.

While there are many definitions of case management, the 2009 definition approved by CMSA is as follows (CMSA, 2009):

**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 quality cost-effective outcomes.**

# IV. Philosophy and Guiding Principles

## A. Statement of Philosophy

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 (Powell & Tahan, 2008). The CMSA's philosophy of case management statement articulates that (CMSA, 2009):

**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 individuals being served, their support systems, the health care delivery systems and the various reimbursement sources. Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. ... 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.**

The philosophy of case management underscores the recommendation that individuals, particularly those experiencing catastrophic injuries or severely chronic illnesses, be evaluated for case management services. The key philosophical components of case management address care that is holistic and client-centered, with mutual goals, allowing stewardship of resources for the client and the health care system. Through these efforts, case management focuses simultaneously on achieving health and maintaining wellness to the highest level possible for each client.

It is the philosophy of case management that when health care is appropriately and efficiently provided, all parties benefit. The provision of case management, working collaboratively with the health care team in complex situations, serves to identify care options which are acceptable to the client. This will, in turn, increase adherence to the plan of care and successful outcomes. Case management reduces the fragmentation of care, which is too often experienced by clients who obtain health care services from multiple providers. Taken collectively, services offered by a case manager can enhance a client's safety, well-being and quality of life, while reducing total health care costs. Thus, effective case management can directly and positively affect the health care delivery system.

## B. Guiding Principles

Guiding principles are relevant and meaningful concepts that clarify or guide practice. Guiding principles for case management practice include the following. Case managers:

- Use a client-centric, collaborative partnership approach.
- Whenever possible, facilitate self-determination and self-care through the tenets of advocacy, shared decision-making, and education.
- Use a comprehensive, holistic approach.
- Practice cultural competence, with awareness and respect for diversity.
- Promote the use of evidence-based care, as available.
- Promote optimal client safety.
- Promote the integration of behavioral change science and principles.

- Link with community resources.
- Assist with navigating the health care system to achieve successful care, for example during transitions.
- Pursue professional excellence and maintain competence in practice.
- Promote quality outcomes and measurement of those outcomes.
- Support and maintain compliance with federal, state, local, organizational, and certification rules and regulations.

Case management guiding principles, interventions, and strategies are targeted at the achievement of client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation.

They are based on the needs and values of the client and are accomplished in collaboration with all service providers. This accomplishes care that is appropriate, effective, client-centered, timely, efficient, and equitable.

# V. Case Management Practice Settings

Case management practice extends across all health care settings, including payer, provider, government, employer, community, and home environment. However, the practice varies in degrees of complexity and comprehensiveness based on the following four factors (Powell and Tahan, 2008):

1. The context of the care setting, such as wellness and prevention, acute, or rehabilitative.
2. The health conditions and needs of the patient population(s) served, as well as the needs of the family/caregivers, such as critical care, asthma, renal failure, hospice care.
3. The reimbursement method applied, such as managed care, workers' compensation, Medicare, or Medicaid.
4. The health care professional discipline designated as the case manager, such as registered nurse, social worker, physician, rehabilitation counselor, etc.

The following is a representative list of case management practice settings; however, it is not an exhaustive list of settings where case managers exist. Case managers work in:

- Hospitals and integrated care delivery systems, including acute care, sub-acute care, long-term acute care (LTAC) facilities, skilled nursing facilities (SNF), rehabilitation facilities.
- Ambulatory care clinics and community based organizations, including student/university counseling and health care centers.
- Corporations.
- Public health insurance programs, e.g., Medicare, Medicaid, state-funded programs.
- Private health insurance programs, e.g., workers' compensation, occupational health, disability, liability, casualty, automotive, accident and health, long-term care insurance, group health insurance, managed care organizations.
- Independent and private case management companies.
- Government-sponsored programs, e.g., correctional facilities, military health care/Veterans Administration, public health.
- Provider agencies and community facilities, i.e., mental health facilities, home health services, ambulatory and day care facilities.
- Geriatric services, including residential and assisted living facilities.
- Long-term care services, including home and community based services.
- Hospice, palliative, and respite care programs.
- Physician and medical group practices.
- Life care planning programs.
- Disease management companies.

## VI. Case Management Roles, Functions, and Activities

It is necessary to differentiate between the terms “role,” “function,” and “activity,” before describing what case managers do. Defining these terms is essential to providing a clear and contextual understanding of the roles and responsibilities of case managers.

A *role* is a general and abstract term that refers to a set of behaviors and expected consequences that are associated with one’s position in a social structure. A *function* is a grouping of a set of specific tasks within the role. An *activity* is a discrete action or task a person performs to address the expectations of the role assumed (See Glossary) (Tahan, Huber, Downey, 2006).

A role tends to consist of several functions and each function is described through a list of specific activities. These descriptions constitute what is known as a “job description” (Tahan, Huber, Downey, 2006). The roles assumed by case managers vary based on the same four factors described in the section entitled, *Case Management Practice Setting*.

The case manager performs the primary functions of assessment, planning, facilitation and advocacy, which are achieved through collaboration with the client and other health care professionals involved in the client’s care. Key responsibilities of case management have been identified by nationally recognized professional societies and certifying bodies through case management roles and functions research.

It is not the intent of the Standards to parallel these key responsibilities; the Standards will broadly define major functions involved in the case management process to achieve desired outcomes.

Successful outcomes cannot be achieved without specialized skills and knowledge applied throughout the process. These skills include, but are not limited to, positive

relationship-building; effective written and verbal communication; negotiation; knowledge of contractual or risk arrangements; the ability to effect change, perform ongoing evaluation and critical analysis; and the ability to plan and organize effectively.

It is important for the case manager to have knowledge of funding sources, health care services, human behavior dynamics, the health care delivery and financing systems, and clinical standards and outcomes. The skills and knowledge base of a case manager may be applied to individual clients, or to groups of clients, such as in disease management or population health models.

Role functions of case managers include:

- Conducting a comprehensive assessment of the client’s health and psychosocial needs, including health literacy status and deficits, and develops a case management plan collaboratively with the client and family or caregiver.
- Planning with the client, family or caregiver, the primary care physician/provider, other health care providers, the payer, and the community, to maximize health care responses, quality, and cost-effective outcomes.
- Facilitating communication and coordination between members of the health care team, involving the client in the decision-making process in order to minimize fragmentation in the services.
- Educating the client, the family or caregiver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, case management, etc., so that timely and informed decisions can be made.

- Empowering the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.
- Encouraging the appropriate use of health care services and strives to improve quality of care and maintain cost effectiveness on a case-by-case basis.
- Assisting the client in the safe transitioning of care to the next most appropriate level.
- Striving to promote client self-advocacy and self-determination.
- Advocating for both the client and the payer to facilitate positive outcomes for the client, the health care team, and the payer. However, if a conflict arises, the needs of the client must be the priority.

## VII. Components of the Case Management Process

The case management process is carried out within the ethical and legal realm 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 tasks described below.

However, note that case management is neither linear nor a one-way exercise. For example, the *assessment* responsibilities will occur at all points in the process, and functions such as *facilitation*, *coordination*, and *collaboration* will occur throughout the client's health care encounter.

Primary steps in the case management process include (Powell & Tahan, 2008):

1. *Client identification and selection:* Focuses on identifying clients who would benefit from case management services. This step may include obtaining consent for case management services, if appropriate.
2. *Assessment and problem/opportunity identification:* Begins after the completion of the case selection and intake into case management and occurs intermittently, as needed, throughout the case.
3. *Development of the case management plan:* Establishes goals of the intervention and prioritizes the client's needs, as well as determines the type of services and resources that are available in order to address the established goals or desired outcomes.
4. *Implementation and coordination of care activities:* Puts the case management plan into action.
5. *Evaluation of the case management plan and follow-up:* Involves the evaluation of the client's status and goals and the associated outcomes.
6. *Termination of the case management process:* Brings closure to the care and/or episode of illness. The process focuses on discontinuing case management when the client transitions to the highest level of function, the best possible outcome has been attained, or the needs/desires of the client change.

# VIII. Standards of Case Management Practice

## A. STANDARD: CLIENT SELECTION PROCESS FOR CASE MANAGEMENT

The case manager should identify and select clients who can most benefit from case management services available in a particular practice setting.

### How Demonstrated:

- Documentation of consistent use of the selection process within the individual organization's policies and procedures.
- Use of high-risk screening criteria to assess for inclusion in case management programs. Examples of high-risk screening criteria include, but are not limited to:
  - Age
  - Poor pain control
  - Low functional status or cognitive deficits
  - Previous home health and durable medical equipment usage
  - History of mental illness or substance abuse, suicide risk, or crisis intervention
  - Chronic, catastrophic, or terminal illness
  - Social issues such as a history of abuse, neglect, no known social support, or lives alone
  - Repeated emergency department visits
  - Repeated admissions
  - Need for admission or transition to a post-acute facility
  - Poor nutritional status
  - Financial issues

## B. STANDARD: CLIENT ASSESSMENT

The case manager should complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each client.

### How Demonstrated:

- Documentation of client assessments using standardized tools, when appropriate. Example criteria may include, but are not limited to the following components (as pertinent to the case manager's practice setting):
  - Physical/functional
  - Medical history
  - Psychosocial behavioral
  - Mental health
  - Cognitive
  - Client strengths and abilities
  - Environmental and residential
  - Family or support system dynamics
  - Spiritual
  - Cultural
  - Financial
  - Health insurance status
  - History of substance use
  - History of abuse, violence, or trauma
  - Vocational and/or educational
  - Recreational/leisure pursuits
  - Caregiver(s) capability and availability
  - Learning and technology capabilities
  - Self-care capability
  - Health literacy
  - Health status expectations and goals
  - Transitional or discharge plan
  - Advance care planning
  - Legal

- Transportation capability and constraints
- Health literacy and illiteracy
- Readiness to change
- Documentation of resource utilization and cost management; current diagnosis(es); past and present course and services; prognosis; goals (short and long term); provider options; and available health care benefits.
- Evidence of use of relevant, comprehensive information and data required for client assessment from many sources including, but not limited to:
  - Client interviews
  - Initial assessment and ongoing assessments
  - Family or caregivers, physicians, providers, other members of the interdisciplinary health care team
  - Medical records
  - Data: claims and/or administrative

**C. STANDARD:  
PROBLEM/OPPORTUNITY  
IDENTIFICATION**

The case manager should identify problems or opportunities that would benefit from case management intervention.

**How Demonstrated:**

- Documentation of agreement among the client, family or caregiver, and other providers and organizations regarding the problems/opportunities identified.
- Documented identification of opportunities for intervention, such as:
  - Lack of established, evidenced-based plan of care with specific goals
  - Over-utilization or under-utilization of services
  - Use of multiple providers/agencies
  - Use of inappropriate services or level of care

- Non-adherence to plan of care (e.g. medication adherence)
- Lack of education or understanding of:
  - The disease process
  - The current condition(s)
  - The medication list
- Medical, psychosocial, mental health and/or functional limitations
- Lack of a support system or presence of a support system under stress.
- Financial barriers to adherence of the plan of care
- Determination of patterns of care or behavior that may be associated with increased severity of condition.
- Compromised client safety
- Inappropriate discharge or delay from other levels of care
- High cost injuries or illnesses
- Complications related to medical, psychosocial or functional issues
- Frequent transitions between settings

**D. STANDARD:  
PLANNING**

The case manager should identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs.

**How Demonstrated:**

- Documentation of relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care.
- Recognition of the client's diagnosis, prognosis, care needs, preferences, preferred role in decision-making, and outcome goals of the plan of care.
- Validation that the plan of care is consistent with evidence-based practice, when such guidelines are available and applicable.

- Establishment of measurable goals and indicators within specified time frames. Example measures could include access to care, cost-effectiveness of care, and quality of care.
- Documentation of client's or client's support system participation in the written case management plan of care; documentation of agreement with plan, including agreement with any changes or additions.
- Facilitation of problem-solving and conflict resolution.
- Evidence of supplying the client with information and resources necessary to make informed decisions.
- Awareness of maximization of client outcomes by all available resources and services.
- Compliance with payer expectations with respect to how often to contact and reevaluate the client or redefine long or short term goals.

**E. STANDARD:  
MONITORING**

The case manager should employ ongoing assessment and documentation to measure the client's response to the plan of care.

**How Demonstrated:**

- Documentation of ongoing collaboration with the client, family or caregiver, providers, and other pertinent stakeholders, so that the client's response to interventions is reviewed and incorporated into the plan of care.
- Verification that the plan of care continues to be appropriate, understood, accepted by client and support system, and documented.
- Awareness of circumstances necessitating revisions to the plan of care, such as

changes in the client's condition, lack of response to the care plan, preference changes, transitions across settings, and barriers to care and services.

- Collaboration with the client, providers, and other pertinent stakeholders regarding any revisions to the plan of care.

**F. STANDARD:  
OUTCOMES**

The case manager should maximize the client's health, wellness, safety, adaptation, and self-care through quality case management, client satisfaction, and cost-efficiency.

**How Demonstrated:**

- Evaluation of the extent to which the goals documented in the plan of care have been achieved.
- Demonstration of the efficacy, quality, and cost-effectiveness of the case manager's interventions in achieving the goals documented in the plan of care.
- Measurement and reporting of the impact of the plan of care.
- Utilization of adherence guidelines, standardized tools and proven processes. These can be used to measure individuals' preference for, and understanding of:
  - The proposed plans for their care
  - Their willingness to change
  - Their support to maintain health behavior change
- Utilization of evidence-based guidelines in appropriate client populations.
- Evaluation of client satisfaction with case management.

**G. STANDARD:  
TERMINATION OF CASE  
MANAGEMENT SERVICES**

The case manager should appropriately terminate case management services based upon

established case closure guidelines. These guidelines may differ in various case management practice settings.

### **How Demonstrated:**

- Identification of reasons for case management termination, such as:
  - Achievement of targeted outcomes or maximum benefit reached
  - Change of health setting
  - Loss or change in benefits (i.e., client no longer meets program or benefit eligibility requirements)
  - Client refuses further medical/psychosocial services
  - Client refuses further case management services
  - Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services (e.g., non-adherence of client to plan of care)
  - Death of the client
- Evidence of agreement of termination of case management services by the client, family or caregiver, payer, case manager, and/or other appropriate parties.
- Documentation of reasonable notice of termination of case management services that is based upon the facts and circumstances of each individual case.
- Documentation of both verbal and/or written notice of termination of case management services to the client and to all treating and direct service providers.
- With permission, communication of client information to transition providers to maximize positive outcomes.

### **H. STANDARD: FACILITATION, COORDINATION, AND COLLABORATION**

The case manager should facilitate coordination, communication, and collaboration with

the client and other stakeholders in order to achieve goals and maximize positive client outcomes.

### **How Demonstrated:**

- Recognition of the case manager's professional role and practice setting in relation to that of other providers and organizations caring for the client.
- Development and maintenance of proactive, client-centered relationships and communication with the client, and other necessary stakeholders to maximize outcomes.
- Evidence of transitions of care, including:
  - A transfer to the most appropriate health care provider/setting
  - The transfer is appropriate, timely, and complete
  - Documentation of collaboration and communication with other health care professionals, especially during each transition to another level of care within or outside of the client's current setting
- Adherence to client privacy and confidentiality mandates during collaboration.
- Use of mediation and negotiation to improve communication and relationships.
- Use of problem-solving skills and techniques to reconcile potentially differing points of view.
- Evidence of collaborative efforts to optimize client outcomes: this may include working with community, local and state resources, primary care physician or other primary provider, other members of the health care team, the payer, and other relevant health care stakeholders.
- Evidence of collaborative efforts to maximize regulatory adherence within the case manager's practice setting.

**I. STANDARD:  
QUALIFICATIONS  
FOR CASE MANAGERS\***

Case managers should maintain competence in their area(s) of practice by having one of the following:

- Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; or
- In the case of an individual in a state that does not require licensure or certification, the individual must have a baccalaureate or graduate degree in social work, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. 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 the education, experience, and expertise required for the case manager's area(s) of practice.
- Compliance with national and/or local laws and regulations that apply to the jurisdictions(s) and discipline(s) in which the case manager practices.
- Maintenance of competence through relevant and ongoing continuing education, study, and consultation.
- Practicing within the case manager's area(s) of expertise, making timely and appropriate referrals to, and seeking consultation with, others when needed.

**J. STANDARD:  
LEGAL**

The case manager should adhere to applicable local, state, and federal laws, as well

as employer policies, governing all aspects of case management practice, including client privacy and confidentiality rights. It is the responsibility of the case manager to work within the scope of his/her licensure.

**NOTE:** In the event that employer policies or the policies of other entities are in conflict with applicable legal requirements, the case manager should understand which laws prevail. In these cases, case managers should seek clarification of any questions or concerns from an appropriate and reliable expert resource, such as an employer, government agency, or legal counsel.

**1. Standard:  
Confidentiality and Client Privacy**

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing the client, client privacy, and confidentiality rights and act in a manner consistent with the client's best interest.

**How Demonstrated:**

- Up-to-date knowledge of, and adherence to, applicable laws and regulations concerning confidentiality, privacy, and protection of client medical information issues.
- Evidence of a good faith effort to obtain the client's written acknowledgement that he/she has received notice of privacy rights and practices.

**2. Standard:  
Consent for Case Management  
Services**

The case manager should obtain appropriate and informed client consent before case management services are implemented.

**How Demonstrated:**

- Evidence that the client and support system were thoroughly informed with

regard to:

- Proposed case management process and services relating to the client's health conditions and needs
- Possible benefits and costs of such services
- Alternatives to the proposed services
- Potential risks and consequences of the proposed services and alternatives
- Client's right to refuse the proposed case management services, and potential risks and consequences related to such refusal

■ Evidence that the information was communicated in a client-sensitive manner, which is intended to permit the client to make voluntary and informed care choices.

■ If client consent is a prerequisite to the provision of case management services, documentation of the informed consent.

#### **K. STANDARD: ETHICS**

Case managers should behave and practice ethically, adhering to the tenets of the code of ethics that underlies his/her professional credential (e.g., nursing, social work, rehabilitation counseling, etc.).

#### **How Demonstrated:**

- Awareness of the five basic ethical principles and how they are applied: beneficence (to do good), nonmaleficance (to do no harm), autonomy (to respect individuals' rights to make their own decisions), justice (to treat others fairly), and fidelity (to follow-through and to keep promises).
- Recognition that a case manager's primary obligation is to his/her clients.
- Maintenance of respectful relationships with coworkers, employers, and other professionals.

■ Recognition that laws, rules, policies, insurance benefits, and regulations are sometimes in conflict with ethical principles. In such situations, case managers are bound to address such conflicts to the best of their abilities and/or seek appropriate consultation.

#### **L. STANDARD: ADVOCACY**

The case manager should advocate for the client at the service-delivery, benefits-administration, and policy-making levels.

#### **How Demonstrated:**

- Documentation demonstrating:
  - Promotion of the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy
  - Education of other health care and service providers in recognizing and respecting the needs, strengths, and goals of the client
  - Facilitating client access to necessary and appropriate services while educating the client and family or caregiver about resource availability within practice settings
  - Recognition, prevention, and elimination of disparities in accessing high-quality care and client health care outcomes as related 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; or other cultural factors
  - Advocacy for expansion or establishment of services and for client-centered changes in organizational and governmental policy

- Recognition that client advocacy can sometimes conflict with a need to balance cost constraints and limited resources. Documentation indicates that the case manager weighed decisions with the intent to uphold client advocacy, whenever possible.

**M. STANDARD:  
CULTURAL COMPETENCY**

The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific client profiles.

**How Demonstrated:**

- Documentation demonstrating:
  - Case manager understands relevant cultural information and communicates effectively, respectfully, and sensitively within the client’s cultural context
  - Assessment of client linguistic needs and identifying resources to enhance proper communication. This may include use of interpreters and material in different languages and formats, as necessary, and understanding of cultural communication patterns of speech volume, context, tone, kinetics, space, and other similar verbal/non-verbal communication patterns
- Evidence of pursuit of education in cultural competence to enhance the case manager’s effectiveness in working with multicultural populations.

**N. STANDARD:  
RESOURCE MANAGEMENT  
AND STEWARDSHIP**

The case manager should integrate factors related to quality, safety, access, and cost-effectiveness in assessing, monitoring, and evaluating resources for the client’s care.

**How Demonstrated:**

- Documentation of evaluating safety, effectiveness, cost, and potential outcomes when designing care plans to promote the ongoing care needs of the client.
- Evidence of follow-through on care plan objectives, including assisting with referral and outsourcing as needed, based on the ongoing care needs of the client and the competency, knowledge, and skill of the health and human services providers.
- Evidence of utilizing evidence-based guidelines, as available, and guidelines specific to the case manager’s practice setting in making decisions about resource allocation and utilization.
- Demonstration of linking the client and family or caregiver with resources appropriate to the needs and goals identified in the care plan. Fully informing the client and family or caregiver of the length of time for which each resource is available, their financial responsibility for each resource, and the anticipated outcome of resource utilization.
- Documented communication of the client and other providers, both internal and external, 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 demonstrating that the intensity of case management services rendered corresponds with the needs of the client.

**O. STANDARD:  
RESEARCH AND RESEARCH  
UTILIZATION**

The case manager should maintain familiarity with current research findings and be able to apply them, as appropriate, in his/her practice.

**How Demonstrated:**

- Evidence of familiarization with current literature pertaining to the case manager's expertise, and regular participation in appropriate training and/or conferences to maintain knowledge and skills.
- Compliance with legitimate and relevant research efforts, in order to quantify and define valid and reliable outcomes in case management.
- Incorporation of meaningful research findings into practice as appropriate.
- Participation in identification of practical, hands-on approaches to case management "best practices."

# IX. Acknowledgements

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# X. Glossary

**Activity:** 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, Huber, Downey, 2006).

**Advocacy:** The act of recommending, pleading the cause of another; to speak or write in favor of.

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

**Care Coordination:** The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care (AHRQ, 2007).

**Care Management:** A health care delivery process that helps achieve better health outcomes by anticipating and linking clients with the services they need more quickly. Case management may help to avoid unnecessary services by reducing medical complications (CCMC, 2009). This term often refers to the management of long-term health care, legal, and financial services by professionals serving social welfare, aging and nonprofit care delivery systems. Services are delivered under a psychological model (Powell & Tahan, 2008).

**Case Management:** A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to facilitate an indi-

vidual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, 2010).

**Case Management Plan of Care:**

A comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; and measurable goals to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client.

**Case Management Process:** The manner in which case management functions are performed, including: assessment, problem identification, outcome identification, planning, monitoring, and evaluating.

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

**Client:** (1) 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, when *client* is used, it may also infer the inclusion of the client’s support. (2) Client can also imply the business relationship with a company who contracts for or pays for case management services. The first definition is the one used throughout the *Standards of Practice 2010*.

**Client Support System:** The client’s support system is defined by each client and may include biological relatives, spouses, partners, friends, neighbors, colleagues, or any individual who supports the client.

**Consumer:** An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as “member,” “enrollee,” “beneficiary,” “patient,” “injured worker,” “claimant,” etc. A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

**Cultural Competence:** The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each (NASW, 2007).

**Culture:** The integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. 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 (Cross, Bazron, Dennis, & Isaacs, as cited in U.S. Department of Health and Human Services, Office of Minority Health, 2001).

**Disease Management:** Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Because of the presence of co-morbidities or multiple conditions in most high-risk patients, this approach may become operationally difficult 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 (DMAA definition).

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

**Family:** Family members and/or those individuals designated by the client as the client’s support system.

**Function:** A grouping of a set of specific tasks within the role. The set of tasks that constitutes one function tends to focus on a common theme and share the same goal; for example, “evaluation of outcomes” or “coordination of treatments” (Tahan, Huber, Downey, 2006).

**Health:** In addition to the four definitions of “health” listed below, case management’s definition of health takes on a more comprehensive meaning that includes biopsychosocial, as well as educational and vocational, aspects of the client:

1. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO Constitution).
2. The extent to which an individual or a group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a resource for everyday life, not the objective of living; it is a positive concept, emphasizing social and personal resources as well as physical capabilities (Health Promotion: A Discussion Document, Copenhagen: WHO 1984).
3. A state characterized by anatomic, physiologic and psychological integrity; ability to perform personally valued family, work

and community roles; ability to deal with physical, biologic, psychological and social stress; a feeling of well-being; and freedom from the risk of disease and untimely death (J. Stokes et al. "Definition of terms and concepts applicable to clinical preventive medicine," *J Common Health*, 1982; 8:33-41).

4. A state of equilibrium between humans and the physical, biologic and social environment, compatible with full functional activity (JM. Last, *Public Health and Human Ecology*, 2nd ed. Stamford, CT: Appleton and Lange, 1997).

**Health Outcomes:** Changes in current or future health status of individuals or communities that can be attributed to antecedent actions or measures (EURO European Centre for Health Policy, ECHP, Brussels, 1999).

**Health Services:** Medical services and/or health and human services.

**Kinetics:** A communication pattern referring to the use of stance, gestures, eye behavior and other posturing by an individual in non-verbal communication.

**Licensure:** Licensure is a process by which a government agency grants permission to an individual to engage in a given occupation, provided that 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 staff. Providers deemed a medical home may receive supplemental payments to support operations expected of a medical home. Physician practices may be encouraged or required to improve practice infrastructure and meet certain qualifications in order to achieve eligibility.

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

**Payer:** An individual or entity that funds related services, income, and/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. Through predictive modeling, data is "mined" with software to examine and recognize patterns and trends, which can then potentially forecast 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, as well as to better risk stratify 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 that are associated with one's position in a social structure. Usually, organizations and employers use a person's title as a proxy for his/her role; for example, "acute care case manager" (Tahan, Huber, Downey, 2006).

**Space:** A communication pattern referring to the physical distance or "comfort proximity"

selected by an individual when communicating with another individual.

**Speech Context:** A communication pattern referring to the use/non-use of emotion by an individual in verbal communication.

**Speech Volume:** A communication pattern referring to the level of loudness or softness used by an individual in verbal communication.

**Standard:** An authoritative statement agreed to and promulgated by the practice by which the quality of practice and service can be judged.

**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 patient moves between one health care service provider to another.

**Transitions of Care:** Transitions of care is 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."

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