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I. FOREWORD

It is our pleasure to present the 2010 revision of the Case Management Society of America’s (CMSA) Standards of Practice (SoP). These Standards were first published in 1995 and revised in 2002. Today, as our nation faces ever greater challenges in our fragmented healthcare system, CMSA recognized the need to revise the SoP 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 healthcare team. These key issues, among others, provided the impetus to re-examine, and even define our proper role in the healthcare matrix.

As healthcare professionals, we could all agree that, on some level, America’s healthcare system is in need of improvement. It is expensive and, some might argue, generally of a poorer quality than care in other parts of the world. As the population becomes older and sicker, case managers will become even more essential to the provision of safe, cost-effective, and satisfying healthcare. In this time of fractured and fragmented healthcare, we can no longer wait to solidify our case management position; the time is “now.”

As our profile becomes ever more visible, it is imperative 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 care and to improve our position for reimbursement of case management services, it is imperative to establish accepted qualifications for case managers. Equally essential towards these goals is the need to validate both our educational training and our positive outcomes as we work with patients through case management interventions. Ultimately these changes strengthen the delivery of case management services and validate the case management professional.

This edition of the Standards of Practice is the product of many hours of labor, research, and deliberation between 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 healthcare 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
CMSA President: 2008-2009
Margaret “Peggy” Leonard
CMSA President: 2009-2010
II. PREFACE

The Standards of Practice for Case Management was first introduced by the Case Management Society of America (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: minimizing fragmentation in the healthcare system, use of evidence-based guidelines in practice, transitions of care, incorporating adherence guidelines and other standardized practice tools, expansion of the interdisciplinary team in planning care for individuals, improving patient safety, to name a few. We believe that these are all important factors that case managers need to address in their practices. The 2010 Standards of Practice document contains 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 three 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 stakeholders deemed important to widen the expert base, and (4) case management 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

III. INTRODUCTION

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

Although a number of strategies for healthcare reform have been espoused and debated, case management has emerged as an important intervention that fosters the careful shepherding of healthcare dollars, while maintaining a primary and consistent focus on patient advocacy.
Founded in 1990, the Case Management Society of America (CMSA) is the leading non-profit association dedicated to the support and development of case management, including the *Standards of Practice for Case Management*.

The strategic **Vision** of CMSA is (CMSA, 2009, Pg. 1):

"We envision case managers as pioneers of healthcare change...key initiators of and participants in the healthcare team who open up new areas of thought...research and development...leading the way toward the day when every American will know what a case manager does and will know how to access case management services."

To support that Vision, CMSA has developed a **Mission Statement** as follows (CMSA, 2009, Pg. 1):

"To positively impact and improve patient well-being and healthcare outcomes."

To compliment these Mission and Vision Statements, 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 healthcare profession, but rather an advanced practice within the varied healthcare professions that serve as a foundation for case management.

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

Some adjustments may be necessary as these Standards are incorporated into individual practices. While the Standards are offered to advance the delivery of case management interventions, they are also intended to be realistically attainable by individuals who use appropriate and professional judgment regarding the delivery of case management interventions to targeted patient / client populations.

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

**IV. ** **Evolution of the Standards of Practice for Case Management**

**Standards of Practice for Case Management (1995)**

In 1995, the President of the Case Management Society of America (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; and they were seen as a guide to move case management practice to excellence. In 1995, the Chair of the Standards Committee wrote: “The Standards of Care refer to the process of case management practice. Standards of Performance are relevant to fulfillment of the case manager role. Together these statements construct a framework for case management which is applicable to public policy, education, practice and research (CMSA, 1995, pg.5).”

The model for case management utilized a triangular template with each point representing the patient/client, the provider and the payer. The case manager was seen as the center to encourage the flow of information, and the effective planning and coordinating, with the patient/client. This model and the Standards, themselves, 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 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 manager basing their individual practice on valid research findings, and they encouraged case managers to participate in the research process, programs, and the 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).

**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. These revised Standards of Practice for Case Management were published in 2002. As was stated in the Foreword (CMSA, 2002, pg. 2):

“The 2002 Standards incorporate changes that are now embedded in case management practice and healthcare. Evolving practice directions, such as population-based care or the use of evidence based guidelines, are noted as emerging trends to be monitored for future updates.”

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 triangular model was revised to place the individual patient/client and case manager in the middle section. Each point was expanded to include the payer, community and healthcare team. The section on Performance Indicators was expanded and elaborated upon 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.

The primary case management functions were expanded in 2002 to include both current and new skills and concepts: positive relationship-building; effective written/verbal communication; negotiation skills; knowledge of contractual and risk arrangements; ability to effect change and perform ongoing evaluation; use of critical thinking and analysis; ability to plan and organize effectively; promote patient/client autonomy; and to be knowledgeable of funding sources, healthcare services, human behavior dynamics, healthcare delivery and financing systems, and clinical standards and outcomes.

- Case management work expanded to apply to individual patient/clients or to groups of patient/clients, such as in disease management or population health models. The facilitation section was expanded to include more detail about the importance of communication and collaboration on behalf of the patient/client and the payer. Other expanded sections included the case manager relationship to the patient/client; the importance of obtaining consent; attention to cultural competency; confidentiality and patient/client privacy; and termination of case management services. 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’ work.

**Standards of Practice for Case Management (2010)**

This version of the *Standards of Practice for Case Management* in 2010 includes topics that are impacting the practice of case management in the current healthcare environment. Included in this revision are:

- Addressing the total individual, inclusive of medical, psychological, social and behavioral health needs.
- Collaborative efforts that focus upon moving the individual to self-care.
- Increased involvement of the individual and caregiver in the decision-making process.
- Minimizing fragmentation of care within the healthcare delivery system.
- Use of evidence-based guidelines, as available, in the daily practice of case management.
- Transitions of care, which includes a complete transfer to the next healthcare provider that is effective, safe, timely, and complete.
- Improving outcomes by utilizing adherence guidelines, standardized tools and proven processes to measure an individual’s understanding of the proposed plans, their willingness to change, and their support to maintain health behavior change.
Expansion of the interdisciplinary team to include the individuals and/or their identified caregivers, healthcare providers, including community-based and facility-based professionals, i.e., pharmacists, nurse practitioners, holistic care providers, etc.

Expansion of case management role to collaborate within one’s practice setting to maximize regulatory adherence.

Moving individuals to optimal levels of health and well-being.

Improving patient safety and patient satisfaction.

Improving medication reconciliation for an individual patient / client through collaborative efforts with medical staff.

Improving medication adherence as well as adherence to the plan of care for an individual patient / client.

These changes advance case management credibility and support the current changes in healthcare to improve outcomes. Future case management Standards of Practices will likely reflect the existing climate of healthcare and build upon the evidence-based guidelines that are proven successful in the coming years.

V. DEFINITION OF CASE MANAGEMENT

The basic concept of case management involves the timely coordination of quality health services to meet an individual’s specific health needs in a cost-effective manner in order to promote positive outcomes. This can occur in an episodic setting or during case management transitions of care throughout many settings. The case manager serves as an important facilitator between the patient / client, 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 reflecting a vibrant and dynamic amplification of the natural progression of the practice of case management. Following more than a year of study and discussion with members of the National Case Management Task Force, the Case Management Society of America’s (CMSA) 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 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 re-visited 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.”

VI. PHILOSOPHY AND GUIDING PRINCIPLES

Statement of Philosophy
A philosophy is a statement of belief that sets forth principles to guide a program and the individual in his or her practice of that program (Powell & Tahan, 2008). The Case Management Society of America’s (CMSA) 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 that all individuals, particularly those experiencing catastrophic and high chronicity injuries or illnesses, should be evaluated for case management services. The key philosophical components of case management address care that is holistic and patient/client-centered, with mutual goals, allowing stewardship of resources for the patient/client and the healthcare system. Through these efforts, case management focuses simultaneously on achieving health and maintaining wellness.

The philosophy of case management is closely aligned with The Institute of Medicine’s (IOM)’s “Six Aims for the 21st Century Health Care System,” as outlined in its published report in 2001 called “Crossing the Quality Chasm.” These Six Aims are synergistic with high quality case management practice and include healthcare that is safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001).

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

**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 should:

1. Use a patient/client-centric, collaborative partnership approach.
2. Promote the right to self-determination through the tenets of advocacy.
3. Use a comprehensive, holistic approach.
4. Practice cultural competence, with awareness and respect for diversity.
5. Facilitate informed choice, consent, and decision-making.
6. Promote the patient / client’s self-care management.
8. Promote the use of evidence-based care, as available.
10. Promote the integration of behavioral change science and principles.
11. Link with community resources.
12. Assist with navigating the healthcare system to achieve successful care transitions.
13. Pursue professional excellence and maintain competence in practice.
14. Promote quality outcomes, including measurement of outcomes.

Case management guiding principles, interventions, and strategies are targeted at the achievement of patient / client stability, wellness, and autonomy through advocacy, assessment, planning, communication, education, resource management, care coordination, collaboration, and service facilitation. Based on the needs and values of the patient / client and in collaboration with all service providers, the case manager links patient / clients with appropriate providers and resources throughout the continuum of health and human services and care settings. This is accomplished through care that is appropriate, effective, patient / client-centered, timely, efficient, and equitable. The case manager is able to enhance these services by maintaining the patient / client's privacy, confidentiality, and health through advocacy and adherence to ethical, legal, accreditation, certification, and regulatory Standards or guidelines.

VII. CASE MANAGEMENT PRACTICE SETTINGS

Case management practice extends across all healthcare settings, including payer, provider, government, employer, community, parochial, 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, or hospice care;
3. The reimbursement method applied, such as managed care, Medicare, or Medicaid; and
4. The background and specialty of healthcare professional 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 exhaustive of settings where case managers exist.

- 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;
- Corporations;
- Public health insurance programs, e.g., Medicare, Medicaid;
- Private health insurance programs, e.g., workers’ compensation, occupational health, disability, liability, casualty, auto, accident and health, long term care insurance, managed care organizations;
- Independent and private case management companies;
- Government-sponsored programs, e.g., military, correctional facilities, TRICARE, public health;
- Provider agencies and facilities, e.g., mental health facilities, home health services, ambulatory and day care facilities;
- Geriatric services including residential and assisted living facilities;
- Long-term care services;
- Hospice, palliative and respite care programs;
- Physician and medical group practices;
- Telephonic triage and call centers;
- Life care planning programs; and
- Disease management companies.

**VIII. 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 meet the expectations of the role assumed (See Glossary).

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.” The roles assumed by case managers vary based on the same four factors described above that impact practice settings.

The case manager performs the primary functions of assessment, planning, facilitation and advocacy, which are achieved through collaboration with the client and other healthcare 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 and promote client autonomy. It is important for
the case manager to have knowledge of funding sources, healthcare services, human behavior dynamics, the healthcare delivery and financing systems, and clinical standards and outcomes. The skills and knowledge-base of a case manager may be applied to individual patient / clients, or to groups of patient / clients, such as in disease management or population health models. Some role functions include:

- The case manager conducts a comprehensive assessment of the patient / client’s health needs and develops a plan of care collaboratively with the client.
- The case manager plans with the patient / client, the primary care physician/provider, other healthcare providers, the payer, and the community, to maximize healthcare response and quality, cost-effective outcomes.
- The case manager facilitates communication and coordination between members of the healthcare team, involving the patient / client in the decision-making process in order to minimize fragmentation of the healthcare delivery system.
- The case manager educates the patient / client and members of the healthcare delivery team about case management, healthcare and treatment options, community resources, insurance benefits, psychosocial concerns, etc., so that informed decisions can be made.
- The case manager problem-solves, exploring options of care when available and alternative plans when necessary to achieve desired outcomes.
- The case manager encourages appropriate use of healthcare services and strives to improve quality of care and maintain cost effectiveness on a case-by-case basis.
- The case manager assists the patient / client in the safe transitioning of care to the next most appropriate level.
- The case manager strives to promote patient / client self-advocacy.
- Ideally, the case manager is an advocate for both the patient / client and the payer to facilitate positive outcomes for the patient / client, the healthcare team and the payer. However, if a conflict arises, the needs of the client must be the priority.

IX. Components of the Case Management Process

Within the ethical and legal realm of a case manager’s roles and functions, and using critical-thinking and evidence-based knowledge, the case management process may be practiced. The overarching themes in the case management process include the following tasks. However, note that case management is neither linear or a one-way exercise; rather, for example, the assessment responsibilities will occur ongoing, and functions such as facilitation, coordination, and collaboration will occur throughout the patient / client’s healthcare encounter. Primary steps in the case management process include (Powell & Tahan, 2008):

1. **Patient / client identification and selection**: Focuses on identifying patients / clients who would benefit from case management services.

2. **Assessment and problem identification**: Begins after the completion of the case selection and intake into case management.

3. **Development of the case management plan**: Establishes goals of the treatment and prioritizes the patient / client’s needs, as well as determine the types of services and resources required to meet 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 patient / client care activities and treatments, and the associated outcomes.

6. **Termination of the case management process:** Brings closure to the care and/or episode of illness, and focuses on discontinuing the case management and the transition of the patient / client to the community-based level of care, including the patient / client’s home.

**X. STANDARDS OF CASE MANAGEMENT PRACTICE**

1. **Standard: Patient / Client Selection Process for Case Management:** The case manager should identify and select patient / clients who can most benefit from case management services available in a particular practice setting.

   **How Demonstrated:**

   - Consistency of the selection process with the individual organization’s policies and procedures.
   - Use of high risk screening criteria to assess for inclusion in case management programs. Some examples of high risk screening criteria include, but are not limited to:
     - >75 ages of age
     - Poor pain control
     - Low functional status
     - Previous home health / durable medical equipment usage
     - History of mental illness or substance abuse
     - Chronic illnesses, e.g. end stage renal disease, diabetes, congestive heart failure
     - Social Issues such as a history of abuse / neglect, no known social family support; lives alone
     - Repeated emergency department visits
     - Repeated admissions e.g., >3 hospitalizations within 6 months
     - Need for admission or transition to a post acute facility
     - Disability
     - Chronic / Terminal illness
     - Poor nutritional status
     - Financial issues

2. **Standard: Patient / Client Assessment:** The case manager should complete a comprehensive, culturally and linguistically sensitive assessment of each patient / client.

   **How Demonstrated:**
• Completion of assessment using standardized tools when appropriate. Some examples may include, but are not limited to the following components as pertinent to the case manager’s practice setting:

  o Physical/functional
  o Medical History
  o Psychosocial
  o Behavioral
  o Cognitive
  o Patient / client strengths and abilities
  o Environmental and residential
  o Family dynamics and support
  o Spiritual
  o Cultural
  o Financial
  o Health insurance status
  o History of substance use
  o History of abuse, violence, or trauma
  o Vocational and/or educational
  o Recreational/leisure pursuits
  o Caregiver(s) capability and availability
  o Learning and technology capabilities
  o Self care capability
  o Health status expectation and goals
  o Transitional or discharge plan
  o Advance care planning
  o Legal
  o Transportation

• Documentation of resource utilization and cost management; current diagnosis(es), past and present treatment course and services; prognosis, goals (short-/long-term), provider options, and available healthcare benefits.

• Use of relevant, comprehensive information and data required for patient / client assessment from many sources including, but are not limited to:

  o Patient / client interviews
  o Initial assessment and ongoing assessments
  o Physicians, providers, other members of the interdisciplinary healthcare team
  o Medical records
  o Data: claims and or administrative

3. **STANDARD: PROBLEM IDENTIFICATION:** The case manager should identify problems that would benefit from case management intervention.

**How Demonstrated:**
• Agreement among the patient / client system and other providers and organizations regarding the problems identified.

• Identification of opportunities for intervention, including, but are not limited to:
  o Lack of established, evidenced-based plan of care with specific goals
  o Over-utilization or under-utilization of services
  o Use of multiple providers/agencies
  o Use of inappropriate services or level of care
  o Non-adherence to plan of care (e.g. medication adherence)
  o Lack of education or understanding of:
    ▪ The disease process
    ▪ The current condition
    ▪ Medication list / medication reconciliation
  o Medical, psychosocial, and/or functional limitations
  o Lack of family/social support/primary caregiver
  o Financial barriers to adherence to the plan of care
  o Family and/or caregiver stress
  o Determination of patterns of care or behavior that may be associated with increased severity of condition
  o Compromised patient safety
  o Inappropriate discharge or delay from other levels of care
  o High cost injuries or illnesses
  o Complications related to medical, psychological or functional issues

4. **Standard: Planning:** The case manager should identify immediate, short-term, and ongoing needs, as well as develop appropriate and necessary case management strategies to address those needs.

**How Demonstrated:**

• Gathering of relevant, comprehensive information and data, using interviews, research, and other methods needed to develop a plan of care.

• Understanding of the patient / client’s diagnosis, prognosis, care needs, 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.

• Establishment of measurable goals and indicators within specified time frames. Measures should include access to care, cost-effectiveness of care, and quality of care.

• Agreement among the patient / client system, providers and other organizations regarding the plan of care.

• Facilitation of problem solving and conflict resolution.

• Supplying all the information necessary to make informed decisions.

• Maximization of patient / client outcomes by all available resources and services.

5. **Standard: Monitoring:** The case manager should employ ongoing assessment and documentation to measure the patient / client’s response to the plan of care.
How Demonstrated:

• Ongoing collaboration with the patient / client system and other providers and organizations, so that the patient / client’s response to interventions is reviewed and incorporated into the plan of care.
• Consideration of circumstances necessitating revisions to the plan of care, such as changes in the patient / client’s condition, lack of response to the care plan, transitions across settings, and barriers to care and services.
• Verification that the plan of care continues to be appropriate, understood and documented.
• Collaboration with the patient / client system and other providers and other organizations regarding any revisions to the plan of care.

6. **STANDARD: OUTCOMES:** The case manager should maximize the patient / client’s health, wellness, safety, adaptation, and self-care.

**How Demonstrated:**

• Evaluation of the extent to which the goals documented in the plan of care have been achieved.
• Evaluation of the efficacy of the case manager’s interventions achieving the goals documented in the plan of care.
• Measuring and reporting of the impact of the plan of care.
• Utilization of adherence guidelines, standardized tools and proven processes to measure individuals’ understanding of the proposed plans, their willingness to change, and their support to maintain health behavior change.
• Use of evidence-based guidelines in appropriate patient / client populations.

7. **STANDARD: TERMINATION OF CASE MANAGEMENT SERVICES:** The case manager should appropriately terminate case management services.

**How Demonstrated:**

• Agreement of termination of case management services by the patient / client, payer, case manager, and/or other appropriate parties.
• Identification of reasons for case management termination, such as:
  o Achievement of targeted outcomes
  o Change of health setting
  o Loss or change in benefits
  o Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services
• 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 written notice of termination of case management services to the patient / client and to all treating and direct service providers.
• With permission, communication of patient information to transition providers to maximize positive outcomes.

8. STANDARD: QUALIFICATIONS FOR CASE MANAGERS: Case managers should maintain competence in their area(s) of practice by having one of the following: a) current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; or b) baccalaureate or graduate degree in social work from a program accredited by the Council on Social Work Education (CSWE); or c) baccalaureate or graduate degree in a 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 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.

9. STANDARD: FACILITATION, COORDINATION, AND COLLABORATION: The case manager should facilitate coordination, communication, and collaboration with the patient / client system and other providers and organizations in order to achieve goals and maximize positive patient / 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 patient / client system.
- Development and maintenance of proactive, patient / client-centered relationships and communication with the patient / client system and other providers and organizations to maximize patient / client system outcomes.
- Evidence of transitions of care - which includes a transfer to the most appropriate healthcare provider - that is effective, appropriate, timely, and complete.
  o Evidence of collaboration with other healthcare professionals, especially during each transition to another level of care within or outside of the patient / client’s current setting.
- Respect for patient / client system privacy and confidentiality 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 patient / client outcomes: this may include working with community, local and state resources, as well as the patient / client or patient / client population, primary care physician or provider, other members of the healthcare team, the payer, and other relevant healthcare stakeholders.
• Evidence of collaborative efforts to maximize regulatory adherence within the case manager’s practice setting.

10. **STANDARD: ETHICS:** Case managers should behave and practice ethically, adhering to the tenets of the code of ethics that underlies her or his 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), non-maleficence (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 or her patient / 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.

11. **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 patient/client privacy and confidentiality rights.

**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.

(a) **Standard: Confidentiality and Patient / Client Privacy:** The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing patient / client and patient / client privacy and confidentiality rights and act in a manner consistent with the patient / client’s best interest.

**How Demonstrated:**
Awareness of current knowledge of, and adherence to, applicable laws and regulations concerning confidentiality, privacy, and protection of patient / client medical information issues.

Evidence of a good faith effort to obtain the patient / client’s written acknowledgement that he/she has received notice of privacy rights and practices.

(b) **Standard: Consent for Case Management Services:** The case manager should obtain appropriate and informed patient / client consent before case management services are implemented.

**How Demonstrated:**

- Evidence that the patient / client / family was thoroughly informed with regard to:
  - The proposed case management process and services relating to the patient / client’s health conditions and needs
  - Possible benefits of such services
  - Alternatives to the proposed services
  - The potential risks and consequences of the proposed services and alternatives
  - The patient / 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 patient / client-sensitive manner, which is intended to permit the patient / client to make voluntary and informed care choices.

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

12. **Standard: Advocacy:** The case manager should advocate for the patient / client system at the service-delivery, the benefits-administration, and policy-making levels.

**How Demonstrated:**

- Promotion of the patient / client system’s self-determination, informed decision-making, autonomy, growth, and self-advocacy.
- Education of other healthcare and service providers in recognizing and respecting the needs, strengths, and goals of the patient / client system.
- Assistance in facilitating patient / client system access to necessary and appropriate healthcare services while, educating the patient / client regarding resource availability within practice settings.
- Recognition, prevention, and elimination of disparities in access to high-quality care and patient / client healthcare 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 identify or gender expression; or other cultural factors.
- Advocacy for expansion or establishment of services and for patient / client-centered changes in organizational and governmental policy.
• Recognition that patient / client advocacy can sometimes conflict with a need to balance cost constraints and limited healthcare resources, and subsequent documentation that the case manager self-evaluates decisions, with the intent to uphold patient / client advocacy whenever possible.

13. **STANDARD: CULTURAL COMPETENCY:** The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific patient / client profiles.

**How Demonstrated:**

• Evidence that the case manager understands relevant cultural information and works effectively, respectfully, and sensitively within the patient / client’s cultural context.
• Assessment of patient / client linguistic needs and identifying resources to enhance proper communication, including 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.
• Self-awareness of the case manager’s values and cultural identities and how his/her values and culture affect work, both with patient/client systems and with other providers and organizations.
• Pursuit of education in cultural competence to enhance the case manager’s effectiveness in working with multicultural populations.

14. **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 patient / client’s care.

**How Demonstrated:**

• Evaluation of safety, effectiveness, cost, and potential outcomes when designing care plan to meet the ongoing care needs of the patient / client system.
• Following through on care plan objectives, including assisting with referral and outsourcing as needed, based on the ongoing care needs of the patient / client system and the competency, knowledge, and skill of the health and human services providers.
• Facilitating the use of both evidence-based guidelines, as available, and guidelines specific to the case manager’s practice setting (or the payer) in making decisions about resource allocation and utilization.
• Linkage of the patient / client system with resources appropriate to the needs and goals identified in the care plan; and fully informing the patient / client system of the length of time for which each resource is available, their financial responsibility for each resource, and the anticipated outcome of resource utilization.
• Communication with the patient / client system and other providers, both internal and external, especially during care transitions between providers and settings, or when there is a significant change in the patient / client’s situation.
• Promotion of the most effective and efficient use of healthcare services and financial resources
• Monitoring of the case manager’s own practice to demonstrate that the intensity of case management services rendered is appropriate to the acuity of the patient / client system’s situation.

15. **Standard: Research and Research Utilization:** The case manager should maintain familiarity with current research findings and be able to apply them as appropriate in her or his practice.

**How Demonstrated:**

• Familiarization with the literature pertaining to the case manager’s expertise, and regular participation in appropriate training and/or conferences to maintain knowledge and skills.
• Participation in legitimate and relevant research efforts as able.
• Incorporation of meaningful research findings into practice as appropriate.
• Participate in identification of practical, hands-on approaches to case management “best practices.”
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XII. Glossary

Activity: is 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.

Advocacy: The act of recommending, to plead 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 healthcare delivery process that helps achieve better health outcomes by anticipating and linking clients with the services they need more quickly. It also helps avoid unnecessary services by preventing medical problems from escalating (CCMC, 2009).

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 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 patient / client.

Case Management Process: Common to performance of case management functions is the process used, including; assessment, problem identification, outcome identification, planning, monitoring, and evaluating.

Certification (from CCMC): CCMC considers certification to be a process by which a government or non-government agency within the United States grants recognition to an individual who has met certain predetermined qualifications set by a credentialing body. To meet CCMC’s requirements, an applicant’s certification must be current and active, and the holder classified as being in good standing by the credentialing body. The certification awarded upon completion of the educational program MUST have been obtained by the applicant’s having taken an examination in his/her area of specialization.
**Patient/Client**: Individual who is the recipient of case management services. It includes, but is not limited to, patient, beneficiaries, injured worker, claimant, enrollee, member, or healthcare consumers. In addition, when “patient / client” is used, it also infers the inclusion of the patient / client’s support system, which may include family or significant others.

**Patient/Client system**: Refers to patient / client and patient / client’s significant other, family members, primary caregiver, and formal and informal support systems.

**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 (NASW, 2009). 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.

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

**Family**: Family members and/or those individuals designated by the patient / client as the patient / 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.”

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


**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 (from CCMC):** CCMC considers licensure to be a process by which a government agency within the United States 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. To meet CCMC’s requirements, an applicant’s license must be current and active in the state in which he or she practices, and the holder classified as being in good standing by the state. If an applicant has successfully obtained licensure through the state, CCMC recognizes each state’s criteria for licensure as fulfilling the licensure requirement.

**Managed Care:** Services or strategies designed to improve access to care, quality of care, and 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:** Medical Home models provide accessible, continuous, coordinated and comprehensive patient-centered care, and are 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 patient / client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle.

**Patient/Client:** Individual who is the recipient of case management services. It includes, but is not limited to, patient, beneficiaries, injured worker, claimant, enrollee, member, or healthcare
consumers. In addition, when “patient / client” is used, it also infers the inclusion of the patient / clients support system, which may include family or significant others.

**Patient/Client system:** Refers to patient / client and patient / clients’ significant other, family members, primary caregiver, and formal and informal support systems.

**Payer:** An individual or entity that funds healthcare 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, managed care 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 patient / client education needs, allocation of finances, as well as to better risk stratify population groups.

**Provider:** The individual, service organization, or vendor who provides healthcare services to the patient / 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.”

**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 healthcare as the patient moves between one healthcare service provider to another.
Transitions of Care: Transitions of care is the movement of patients from one healthcare practitioner or setting to another as their condition and care needs change. Also known as “care transitions.”

XIII. REFERENCES


