Case Management

Standards of Practice & Scope of Services

AMERICAN CASE MANAGEMENT ASSOCIATION

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OUR MISSION

To be THE Association for Health Care Delivery System Case Management and Transitions of Care (TOC) Professionals

Print copies are available for purchase online:
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STANDARDS OF PRACTICE & SCOPE OF SERVICES

for Health Care Delivery System Case Management and Transitions of Care (TOC) Professionals

INTRODUCTION

Case Management in health care delivery systems is a process that occurs across multiple settings and represents a wide range of services that are delivered to patients and their support systems. Recognizing that the field of Case Management continues to evolve, the purpose of this document is to clarify and create common understanding of the scope of service and standards of practice. The American Case Management Association describes Case Management in the following context:

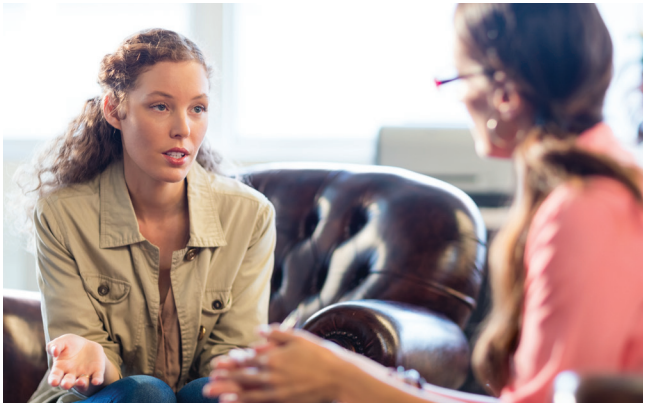
> *Case Management in health care delivery systems is a collaborative practice including patients, caregivers, nurses, social workers, physicians, payers, support staff, other practitioners and the community. The Case Management process facilitates communication and care coordination along a continuum through effective transitional care management. Recognizing the patient's right to self-determination, the significance of the social determinants of health and the complexities of care, the goals of Case Management include the achievement of optimal health, access to services, and appropriate utilization of resources.*

This document describes the scope of services that are provided by Case Management professionals across various settings and includes processes and services that patients and their support systems can expect to receive. Functions described here may vary by setting and role but are

intended to define the continuum of services that are provided by health care delivery system case managers. There are many references made to functions that are performed under the umbrella of "Transitions of Care." This document is not intended to serve as a comprehensive framework for transitions of care but to define the case manager's role in that process.

Please refer to the ACMA Transitions of Care Standards for comprehensive standards and measures. https://transitionsofcare.org

Also included in this document are standards of practice under which every case manager performs. These standards are intended to provide the professional parameters by which case managers deliver care and conduct themselves within their organizations. The continuum of care recognizes the role Case Management professionals have in working collaboratively with physician leaders to achieve quality, patient-centric and value-based outcomes through evidence-based care strategies. http://www.aplcm.org/standardsandscope



SCOPE OF SERVICES

EDUCATION

- For all individuals identified at risk for poor care transitions, Case Management professionals are expected to ensure and provide education relevant to the effective progression of care, appropriate level of care and safe patient transition.
- Deliver education in the ways that patients identify are best for them to receive the information and validate proficiency and understanding by using teach-back methods.
- Validate that education regarding the injury/clinical/disease process has been provided by the health care team in consideration of patient/family/caregiver's level of health literacy.
- Provide information to the health care team, patient/family/caregiver regarding available resources and benefits for services across the continuum that ensures patient choice, safety and timeliness with each transition.

CARE COORDINATION

- Case Management is expected to have a defined method for screening/identification and assessment of individuals in need of active Case Management services. Additionally, Case Management must have defined standards for ongoing monitoring and interventions that advance the progression of care and must include the clinical, psychosocial, financial and operations aspects of care.
- Bi-directional communication is central to care coordination which is a vital function in patient care. Collaborating with team members and providing information is critical to patient care, patient safety, successful outcomes and seamless transitions.

SCREENING/IDENTIFICATION

- Case Management will screen all patients for clinical, psychosocial, financial and other factors that may affect the progression of care. Patients are stratified based on risk/barriers/strengths or the need for Case Management services.

ASSESSMENT

- Case Management must have a defined assessment process that explores the risks identified in the screening process and is complementary to the assessment of other clinical disciplines.
- Identifies clinical, psychosocial, historical, financial, cultural and spiritual needs that guide the planning process with the patient to attain optimal outcomes.
- Determines patient/family/caregiver level of health literacy.
- Evaluates the potential impact of social determinants of health that may elevate the risk of a poor transition.
- Documentation is included in the patient's medical record and readily accessible to all other care team members.

PLAN OF CARE

- Collaborates with patients/families/caregivers in goal setting that is reflective of the location of care.
- Evaluates the patient's/family's/caregiver's level of understanding and engagement with the progress toward goals and incorporates findings into the plan of care.
- Arranges services among community agencies, provider, patient/family/caregivers and others involved in the plan of care.
- Develops a plan that is clinically appropriate and focused on the patient's care needs and goals for care and treatment plan is consistent with patient choice and available resources.
- Monitors progress toward the goals of the plan and ensures revisions in response to changes in patient needs and condition.

- Elicits and incorporates the realistic expectations of patients/family/caregiver/health care team members and payers in the planning process.
- Identifies barriers to achieving recommended goals identified in the plan of care.

SEQUENCING

- Facilitates the progression of care by advancing the care plan to achieve desired outcomes and integrates the work of the health care team by coordinating resources and services necessary to accomplish agreed-upon goals.
- Ensures timely sequencing of interventions for optimal results and smooth transition along the continuum.
- Case Management will actively intervene and resolve/escalate where barriers to service exist.
- Proactively identifies, communicates and resolves barriers that impede the progression of care.
- Case Management is responsible for documenting information that supports and contributes to the progression of care.

TRANSITION MANAGEMENT

https://transitionsofcare.org

- Based on patients' goals, the health care team's assessment, risks and available resources, the case manager is expected to integrate these key elements in order to develop and coordinate a successful transition plan. Transition management planning begins at the time of Case Management's initial patient encounter and is reevaluated and adjusted throughout the patient's episode of care.
- Case managers facilitate bi-directional communication to enhance the handover of care from one setting to another. This may include but is not limited to verbal, written and electronic transfer of information. The goal of communication is always to promote the patient's well-being in the next phase of care. Communication occurs between the patient, the patient's support system, interdisciplinary care team members including providers, community-based services, and others who may be involved in the patient's care. The case manager facilitates communication of biopsychosocial data and additional relevant information in a timely, thorough and accurate manner. Electronic communication of this data is enhanced with verbal communication when necessary.

LONGITUDINAL CARE MANAGEMENT

- A strategy to ensure the coordination of care delivered in multiple settings over a period of time versus an episode where an accountable and an appropriate identified skilled/licensed individual and/or patient/family/caregiver has responsibility for care management, each ensuring the application of ACMA Transitions of Care Standards and/or the compliance of the care plan for optimal patient outcomes.

IDENTIFICATION

- For those patients at risk for adverse health consequences, Case Management will utilize appropriate screening tools and apply interventions to proactively address these risks.
- Identify root cause for readmission to include patient/family/caregiver perspective and implement strategies to reduce future risk.

IMPLEMENTATION

- Case Management will arrange/ensure all elements of the transition plan are implemented and communicated to key stakeholders including, not limited to, the health care team, patient/family/caregiver, payers and post-acute providers.
- Case Management will convey all necessary information for continuity of care and patient safety, verify receipt

Case Management will arrange/ensure all elements of the transition plan are implemented and communicated to key stakeholders including, not limited to, the health care team, patient/family/ caregiver, payer and post-acute providers.

and provide a venue for additional questions and/or information requests/needs.

COMMUNITY PARTNERSHIPS

- Case Management will identify available community resources/potential partners and advocate for resolution of gaps in the available resources and processes.
- Case managers will be knowledgeable of and provide available information for patients to make an informed choice regarding resources/providers.

FOLLOW-UP

- Case Management will support a mechanism to ensure a method of contacting the patient/family/caregiver within a timeframe appropriate to the site of care in order to validate the success of the transition and make their best effort to resolve any identified barriers to the plan of care.

COMPLIANCE

- Case Management will be knowledgeable of and ensure compliance with the federal, state, local organization and accreditation requirements that not only impact their scope of services but affect their ability to advocate for the patient.
- Case Management organizational structure, staffing, policies and procedures must meet the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation.
- All disciplines function within the scope of practice as defined by state licensing regulations.
- Case Management adheres to organizational policies, rules and regulations to promote prevention of fraud and abuse.
- Case Management discloses any potential or perceived conflict of interest based on organizational policies.

UTILIZATION MANAGEMENT

- Case Management is expected to advocate for the patient while balancing the responsibility of stewardship for their organization, and in general, the judicious management of resources.

MEDICAL NECESSITY

- Case Management promotes and facilitates care delivery for the setting and duration that is appropriate to the clinical need.
- Hospital Case Management will have a defined method to ensure the patient is in the appropriate status, level of care and length of stay for the patient's clinical condition.
- The process must include a method for secondary review when warranted per organizational policy or regulatory requirement.

PAYER INTERFACE

- Case Management, with respect to payer requirements, will ensure timely notification and communication of pertinent clinical data to support admission, clinical condition, continued stay and authorization of transitional services.
- When a lack of concurrence exists between the patient's needs and the payer's authorization, Case Management will advocate for securing reimbursement/resources needed for patient care.
- When no payer authorization requirements exist, Case Management accepts the role as a patient and organizational advocate to manage the utilization of resources.
- Payer case manager will provide timely authorizations for services in accordance with accreditation standards and organizational policies.

MANAGING UTILIZATION AND DELAYS

- Case Management will utilize a validated system/defined methodology for tracking avoidable delays/days as well as over/under utilization of resources. This information will be used to identify and communicate opportunities for improvement.
- Case Management will participate in the development of performance improvement activities relevant to identified opportunities.

CONCURRENT DENIALS/APPEALS

- Case Management will proactively prevent medical necessity denials by providing education to physicians, staff and patients, interfacing with payers and documenting relevant information.
- Case Management will provide the clinical information necessary for the appeals process of cases for which a denial of care or services has been received.
- Case Management will utilize a process to escalate and resolve a denial to secure payment for the necessary care and services provided to the patient.

STANDARDS OF PRACTICE

I. ACCOUNTABILITY

- Recognizes and demonstrates shared accountability, both at the patient and the team levels.
- Utilizes an organizationally defined escalation process to refer facets of the care plan beyond the control or influence of the team.
- Contributes to decision-making and decision support as a member of the interdisciplinary team.

II. PROFESSIONALISM

- Aligns practice with the mission, vision and values of their health care organization.
- Emulates the standards of practice for both Case Management and their professional discipline.
- Maintains appropriate licensure and certifications.
- Adheres to the ethical standards as prescribed by the applicable professional discipline and employer code of conduct.
- Adheres to the ACMA Code of Conduct (https://www.acmaweb.org/codeofconduct) and maintains a practice free from outside influence in all professional transactions.
- Recognizes situations that require referral to quality or risk management and makes a timely referral.
- Commits to ongoing learning and strives to improve competence in all areas of practice.
- Advances the application of research and evidence-based practices.
- Participates in the orientation and training of students and new department members and interdisciplinary team members.
- Demonstrates commitment, initiative, integrity and flexibility.
- Embraces and promotes innovation and technology to improve collaboration and patient outcomes.
- Evaluates regularly his or her own performance and sets goals for personal and professional development.
- Utilizes data to drive performance improvement.
- Communicates effectively regardless of modality, considers societal and/or cultural influences and identifies/resolves any communication obstacles.
- Identifies areas of opportunity to provide education to other professionals regarding barriers that patients and their support systems encounter as well as means to resolve those barriers as with mitigation strategies.
- Maintains current knowledge of health care economics, trends and reimbursement methodologies, and applies this knowledge to daily practice. Accepts responsibility as a financial steward.

III. COLLABORATION

- Partners with patients/families/caregivers/community-based organizations and the health care team to jointly communicate, problem solve and share accountability for optimal outcomes.
- Respects and incorporates patients' goals of care and treatment preferences while respecting available resources.
- Recognizes and values the contribution of all disciplines.
- Builds and maintains relationships that foster trust and confidence.
- Engages with physician leaders to provide education and promote optimal patient care. http://www.aplcm.org

IV. ADVOCACY

- Advocates on behalf of patients/family/caregivers for service access or creation, and for the protection of the patient's health, well-being, safety and rights.
- Identifies the legal decision maker (patient or surrogate).
- Ensures patient or surrogate receives information on benefits, risks, costs and treatment alternatives including the option of no treatment.
- Promotes and supports the patient's self-determination in care decisions and assists the health care team's understanding of and respect for the patient's or surrogate's choice.
- Promotes and engages in culturally competent care.
- Providers and payers partner to ensure the patient can access their full benefits and negotiates for benefit exceptions as needed.
- Provides patient/family/caregivers available tools/ resources including pertinent quality measures to make informed choices.
- Demonstrates the ability to balance resources with patient preferences.
- Ensures that suspected cases of abuse, neglect or exploitation have been referred/reported to the appropriate parties and/or agencies.
- Utilizes the ethics committee or other resources to address bioethical issues impacting patient care.
- Promotes the understanding and use of advance care planning and ensures patient goals of care are respected.
- Promotes the professional practice of Case Management.

V. RESOURCE MANAGEMENT

- Manages cost of care with the benefits of patient safety, clinical quality, risk and patient satisfaction to provide recommendations and decisions that ensure optimal outcomes.
- Educates patients/families/caregivers on the financial impact of their care options.
- Informs the interdisciplinary team of the economic impact of treatment options.
- Facilitates timely progression to the appropriate level of care.
- Identifies and addresses avoidable delay practice patterns that may require modification to support cost-effective care. Uses escalation process as needed.
- Identifies and implements strategies for avoiding and/or managing unnecessary costs.
- Applies knowledge of contractual arrangements and payment models to daily practice.
- Manages patient/family/caregiver expectations for short and long-term goals based on health status, prognosis and available resources.

VI. TECHNOLOGY

- Embraces and incorporates innovation and technology to improve collaboration and patient outcomes.
- Utilizes technology to identify and engage with patients/families/caregivers that may benefit from Case Management services.
- Leverages technology to support access to services and augment and prioritize Case Management function.
- Promotes technology that supports Case Management work at the top of a professional's license and the practice standards.
- Ensures compliance with organizational policy and regulatory requirements to securely transmit patient information and protect their health information.

VII. CERTIFICATION

- Certification validates a case manager's knowledge, competency and skills. Case managers holding an Accredited Case Manager™ (ACM-RN/SW) credential have demonstrated that they are especially qualified to provide Case Management services within a health care delivery system.

ACMA POSITION STATEMENT

(approved on December 2, 2016)

Nurses and Social Workers with 36 months of health delivery system experience should have their Accredited Case Manager credential, ACM, to practice Health Delivery System Case Management. ACM exam eligibility requires a minimum of twelve (12) months of Health System Case Management experience.

AMERICAN CASE MANAGEMENT ASSOCIATION

ACMA strives to support health care delivery system case management and Transitions of Care (TOC) professionals by providing:

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