CMSA®
CASE MANAGEMENT SOCIETY OF AMERICA

Standards of Practice
for Case Management

Revised 2016

Standards of Practice for
Case Management

REVISED 2016©

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Foreword

It is my honor to present the 2016 revision of the Case Management Society of America's (CMSA) *Standards of Practice for Case Management.* CMSA, an interprofessional organization, remains dedicated to the support and development of case management professionals. An outstanding hallmark of our profession is the willingness of its members to help one another learn and, thereby, improve the services that our profession performs. Unity is truly our strength. This fourth revision of our Standards of Practice came together with that same united commitment to excellence as seen within our profession.

We recognized the need to revise the *Standards of Practice* in order to be reflective of the expanding role of the professional case manager. The awareness that case managers are crucial members of the health care team has been realized providing the need to reexamine and redefine our role in the current complex health care tomography. The body of knowledge required to practice case management is rapidly growing as the specialty continues to evolve. Modern patient care must be based upon the holistic intertwining of information from a variety of disciplines. As our activities become more sophisticated, so must our resources which in turn must remain relevant.

Professional case management is neither linear nor a one-way exercise. Facilitation, coordination and collaboration occur throughout the client's health care encounter. Collaboration among physicians, nurses, case managers, social workers, pharmacists, allied health professionals, and support staff is critical in achieving the goals of the team, the organization and changing the way we deliver healthcare today. Unity is our strength and this edition of the *Standards of Practice*, is the product of many hours of literature review, discussion, deliberation and collaboration among those who served on the taskforce (see page 31). It is this total body of work we are so proud to roll out.

Before I close I would be remiss if a special thank you was not given to the key to our success, Cheri Lattimer, our Executive Director. Cheri worked tirelessly as our facilitator from beginning to end and through her support and guidance we were able to bring this project to fruition. We could not have completed it to this caliber without her leadership and for this we are grateful.

Lastly I want to dedicate these standards, to all of the professional case managers who make a difference every day in the lives of their clients. My dear late father knew firsthand what a case manager could accomplish and he would frequently ask "What do people do without a Kathleen?" My hope is that in the not so distant future, such question will not need to be asked any longer because all people with complex conditions will have case managers who make their health care experience exponentially greater.

Kathleen Fraser, MSN, MHA, RN-BC, CCM, CRRN
President 2014-2016

Preface

The Case Management Society of America (CMSA) first introduced the *Standards of Practice for Case Management* in 1995 and revised them in 2002 and 2010 thereafter. CMSA and its Board of Directors are pleased to offer the *Standards of Practice for Case Management*, 2016 revision, which provides practice guidelines for the case management industry and its diverse stakeholders. These *Standards of Practice* identify and address important foundational knowledge, skills, and competencies for the professional case manager within a spectrum of case management practice settings, specialties, and health and human service disciplines.

Similar to past revisions, the 2016 Standards reflect recent changes in the industry, which resonate with current practice. Some of these changes include the following:

- Minimizing fragmentation in the health care system, application of evidence-based guidelines in practice to promote collaborative care coordination, navigating transitions of care, and incorporating adherence guidelines and other standardized practice tools.
- Expanding and maximizing the contribution of the interprofessional collaborative health care team to planning care and services for individuals, improving the experience of those who are the recipients of professional case management services, and ensuring safe, quality and cost-effective outcomes.

We believe these are all important factors that professional case managers need to address in their practice. The 2016 Standards of Practice contain information about case management including an updated definition, practice settings, roles and responsibilities, case management process, philosophy and guiding principles, as well as the standards and how they are demonstrated.

This document is intended for voluntary use. It is not intended to replace professional judgment or relevant legal, ethical or optimal practice requirements. In all cases, case managers should consult their own compliance and legal advisors. CMSA provides these Standards of Practice as a resource to professional case managers and in no event shall CMSA be held liable for damages of any kind in connection with the material, methods, information, techniques, opinions, or procedures expressed, presented, or illustrated in these Standards of Practice even if CMSA has been information of the possibility of such liability.

Our hope is that the Standards of Practice serve as a unifying force for professional case management practice by providing a common understanding and application of the role, process, and expectations. As such, the Standards serve to drive accountability for best practice for individual professional case managers as well as for the organizations within which they work.

A dedicated team of expert and professional case managers spent countless hours in synthesizing relevant information from recent changes and developments in the industry. The 2016 revision of the Standards reflect what this team thought to be important for the professional practice of case management. The team included:

1. A core task force made up of representatives of the case management field from various practice settings and professional disciplines.
2. A larger reference group that included the CMSA leadership and Board of Directors, legal advi-

sors, and the case management industry.
3. Other case management experts in the industry who acted in a peer review capacity.

It has been our 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.

Mary Beth Newman, MSN, RN-BC, CCP, CCM, CHCQM, 2016 Taskforce Co-Chair
Kathleen Fraser, MSN, MHA, RN-BC, CCM, CRRN, 2016 Taskforce Co-Chair

I. Introduction

The consistent delivery of quality health and human services and the high financial costs generally associated with these services are important concerns that touch everyone, from our leaders in Washington, D.C., to health care providers, and ultimately the American public at large. Payers today continue to seek innovative methods to reduce costs while advancing quality, safety, optimal care experience, and transparency in outcomes of care. Providers explore innovative ways to define, impact, and report on the value of professional case management services and their benefits to all stakeholders while maximizing reimbursement. Too frequently however, the health care consumer is still left to wander a complex health care system without the necessary support, tools, resources, or knowledge to self-manage complex care needs in an effective, timely, and safe manner. All of these dynamics will continue to shape the context and effects of case management.

A number of recently enacted regulations, such as the Patient Protection and Affordable Care Act (PPACA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, has resulted in the emergence and legitimization of case management as a necessary care delivery model and intervention. The PPACA has reduced the rate of the uninsured and demanded health care providers and organizations to transform their care provision practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improvements in the access to and distribution of resources while the HITEC Act has promoted the adoption and meaningful use of health information technology. Simultaneously, initiatives such as the Value-based Purchasing programs and the National Quality Strategy that is guided by the Institute of Healthcare Improvement's Triple Aim have contributed to better care, improvements in the health of people and communities, and the availability of affordable services. Through case management, health care providers and organizations are able to meet or exceed the quality, safety, and cost related expectations of these key regulations and programs.

Professional case management today fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on quality of care, safe transitions, timely access to and availability of services, and most importantly client self-determination and provision of client-centered and culturally-relevant care. These without a doubt enhance the health of individuals and communities. They also demand a professional case manager who (a) is academically prepared in a health or human services discipline; (b) possesses an unrestricted license or certification as required by the jurisdiction of employment; (c) is able to function independently and according to the scope of practice of the background health discipline; (d) demonstrates current knowledge, skills, and competence to effectively provide holistic and client-centered care; and (e) acts in a supervisory capacity of other personnel who are involved in the client's care but unable to function independently due to limitations of license and/or education.

Founded in 1990, the CMSA is the leading non-profit and interprofessional association dedicated to the support, development, and advancement of case management. The strategic vision of CMSA approved in 2009 and slightly modified in 2016 is as follows:

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

To complement this vision, case management professionals, 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 in 1992, and with each subsequent revision, the S*tandards of Practice for Case Management* have served the professional practice of case management. These Standards, described within this document, are not intended to be a structured recipe for the delivery of case management services and interventions. Rather, they are recommendations for practice and present a range of core functions, roles, responsibilities, and relationships that are integral to the effective interprofessional practice of case management.

The review process of the *Standards of Practice for Case Management* encourages vigorous discussion of each section and necessitates certain updates where appropriate to assure the Standards remain relevant and reflective of current knowledge and practice. The following are important considerations to bear in mind when reading and applying the Standards:
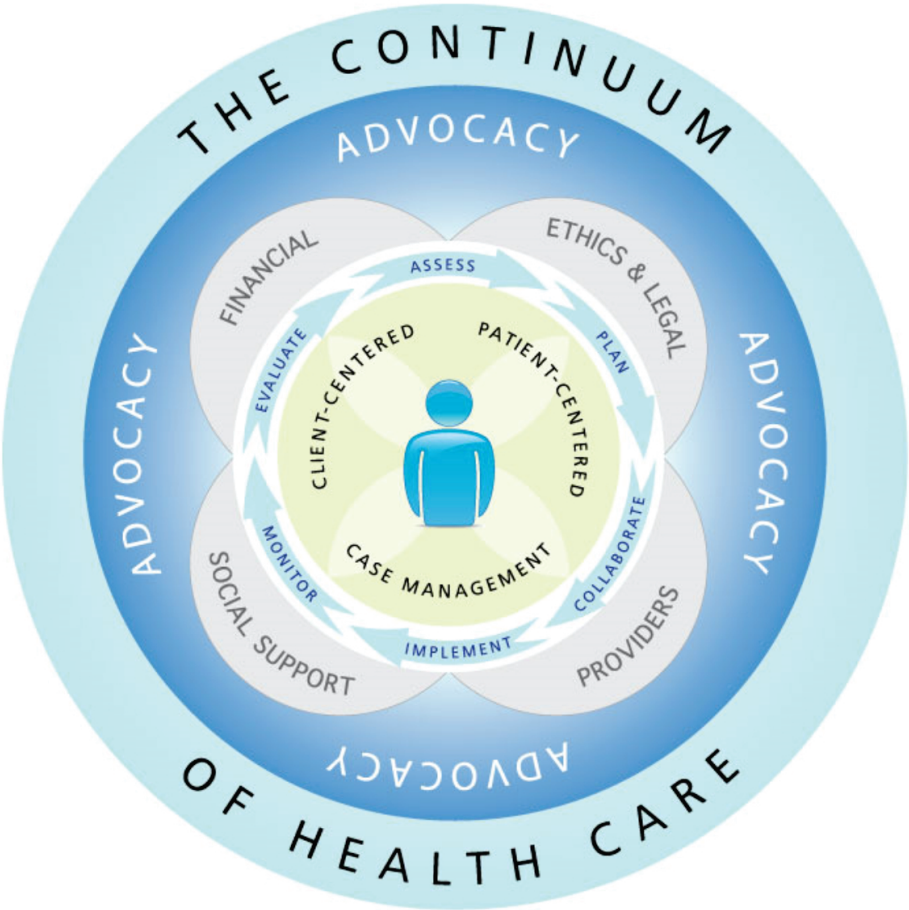
• The term *client* is consistently used throughout the Standards and refers to the individual recipient of case management services. The one exception is Figure 1, The Continuum of Health Care and Professional Case Management, on page 7, in which both client and patient are used. Depending on the practice setting, this individual may be referred to as the patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident or health care consumer. Client is not an age-dependent term. It is recognized that the term client has a context-specific meaning. Client may also imply the business relationship with a company that contracts, or pays, for the delivery of case management services. Careful interpretation and application of the Standards in these diverse contexts is advised to avoid unintentionally or inappropriately advocating for the individual or organization which has contracted the services versus the individual who is the actual recipient of case management services.

• The term *support system*, as indicated by the client, may include a biological relative, spouse, partner, friend, neighbor, colleague, health care proxy, or any individual supporting the client.

• The term *caregiver* is important to recognize. As part of the client's *support system*, a caregiver is the individual designated by the client to be involved in the client's care throughout and following the engagement of case management services. The caregiver, also referred to as family caregiver, is not a member of the interprofessional health care team; rather a member of the client's support system. Note that when using the term "client," it may also be inclusive of the client's support system, family or family caregiver.

• The term *case management* is used throughout the Standards rather than a variety of terms (e.g., care management, care coordination, transitional care). The Glossary includes a definition for each of these terms. For consistency purposes, the term case management is used throughout the Standards as an inclusive term.

• The term *case management plan of care* is used to indicate the individualized and client-centered plan for the provision of care, services, and resources necessary to meet the client's identified care goals, needs, and preferences.

When applying the Standards into individual practice and care settings, adjustments in terminology may be necessary. As previously noted, the Standards primarily use *client;* however, the setting of care rubric may use another term (e.g., member, resident, beneficiary, enrollee, claimant, patient, and individual). In this situation, substitution of terminology is not only acceptable, but advised as well to maintain consistency with the practice setting requirements.

FIGURE 1: The Continuum of Health Care and Professional Case Management

THE CONTINUUM OF HEALTH CARE

ADVOCACY

FINANCIAL

ETHICS & LEGAL

SOCIAL SUPPORT

PROVIDERS

ASSESS

PLAN

COLLABORATE

IMPLEMENT

MONITOR

EVALUATE

CLIENT-CENTERED

PATIENT-CENTERED

CASE MANAGEMENT

While the Standards of Practice are offered to standardize the process of case management, they are intended to be realistic and attainable by members of the interprofessional health care team who use appropriate and reasonable clinical judgment regarding the delivery of professional case management services.

Additionally, the Standards serve to depict the scope of case management practice to colleagues, employers of case managers, health care consumers, legislators, policy makers, and other stakeholders who partner 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 professionals would use 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 of the case management process, 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 related legal and ethical requirements. Even at that first juncture, the Standards committee recognized the importance of the case managers basing their individual practice on valid research findings. The committee encouraged case managers to participate in the research process, programs, and development of specific tools for the effective practice of case management. This was evidenced by key sections that highlighted measurement criteria in the collaborative, ethical, and legal components of the Standards (CMSA, 1995).

B. Standards of Practice for Case Management (2002)

The 2001 Board of Directors of CMSA identified the need for a careful and thorough review and, if appropriate, revision of the 1995 published Standards. The revised *Standards of Practice for Case Management* were then published in 2002. The previously articulated definition of case management was amended at the time to highlight the importance of the case manager's role in client advocacy (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 also 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 the client's appropriate access to care and services.

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

The Standards in 2002 indicated that case management work applied to individual clients or to groups of clients, such as in disease management or population health models. The facilitation section of the Standards 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 practiced.

C. Standards of Practice for Case Management (2010)

The 2010 *Standards of Practice for Case Management* addressed topics that influenced the practice of case management in the dynamic health care environment while the definition of case management generally remained as that articulated in 2002. Included in the 2010 revision however were (CMSA, 2010):

- Addressing the total individual, inclusive of medical, psychosocial, behavioral, and spiritual needs.
- Collaborating efforts that focused 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 included a client's transfer to the next care setting or provider while assuring effective, safe, timely, and complete transition.
- Improving outcomes by using 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, and 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.

Those changes advanced case management credibility and complemented the trends and changes in the health care delivery system occurring at the time.

D. Standards of Practice for Case Management (2016)

During the 2010's revision of the *Standards of Practice for Case Management,* the team involved thought that future case management Standards of Practice would likely reflect the climate of health care and build upon the evidence-based guidelines that were to be proven successful in the coming years. That prediction was not far from becoming reality.

The impetus for the 2016's revision of the *Standards of Practice for Case Management* is the need to emphasize the professional nature of the practice and the role of the case manager. The maturity of the practice of case management, the importance of protecting the professional role of case managers, and the enactment of new laws and regulations including

the Patient Protection and Affordable Care Act, all legitimize professional case management as an integral and necessary component of the health care delivery system in the United States.

It is important to note that the 2016 *Standards of Practice for Case Management* remain primarily similar to and aligned with those released in 2010 except for some modifications which are meant to communicate the value of professional case management practice and demonstrate adherence to relevant and recently enacted laws and regulations. The revised Standards:

- Update the definition of *case management* to reflect recent changes in the practice.
- Clarify who the *professional case manager* is and the qualifications expected of this professional.
- Emphasize the practice of *professional case management* in the ever-expanding care settings across the entire continuum of health and human services, and in constant collaboration with the client, client's family or family caregiver, and members of the interprofessional health care team.
- Communicate *practical expectations* of professional case managers in the application of each Standard. These are found in the "how demonstrated" section that follows each Standard.

- Reflect legislative and regulatory changes affecting professional case management practice such as the need to include the *client's family or family caregiver* in the provision of case management services and to the client's satisfaction.
- Replace the use of stigmatizing terms such as *problems and issues* with others that are empowering to the client such as *care needs and opportunities*.
- Communicate the *closure* of professional case management services and the case manager-client relationship instead of *termination* of services and/or the case management process. This subtle change is better reflective of the reality that despite case closure, a client may continue to receive health care services however not in a case management context.
- Emphasize the provision of *client-centered and culturally and linguistically-appropriate* case management services.
- Highlight the *value of professional case management* practice and the role of the professional case manager.
- Recognize the need for professional case managers to engage in *scholarly activities*, including research, evidence-based practice, performance improvement and innovation, and life-long learning.

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 and safe manner in order to promote optimal outcomes. This can occur in a single health care setting or during the client's transitions of care throughout the care continuum. The professional case manager serves as an important facilitator among the client, family or family caregiver, the interprofessional health care 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 the dynamic health environment. The definition was modified in 2002 to reflect the process of case management outlined within the Standards. It was again revisited in 2009 and modified to further align with the practice of case management at the time. The definition was 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.

While one may believe that the 2009 definition of case management remains appropriate today, with the recent focus on client safety, the CMSA Board of Directors has decided to explicitly reference safety in the 2016 definition:

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 patient safety, quality of care, and cost effective outcomes.

IV. Philosophy and Guiding Principles

A. Statement of Philosophy

A philosophy is a statement of belief and values that sets forth principles to guide a program, its meaning, its context, and the role of the individual(s) that exist in it. The CMSA's philosophy of case management articulates that:

- The underlying premise of case management is based in the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individual client being served, the client's family or family caregiver, the health care delivery system, the reimbursement source or payer, and other involved parties such as the employer and consumer advocates.
- Professional case management serves as a means for achieving client wellness and autonomy through advocacy, ongoing communication, health education, identification of service resources, and service facilitation.
- Professional case management services are best offered in a climate that allows client's engagement and direct communication among the case manager, the client, the client's family or family caregiver, and appropriate service personnel, in order to optimize health outcomes for all concerned (CMSA, 2009).

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

including the diverse group of stakeholders. Through these efforts, case management focuses simultaneously on achieving optimal health and attaining wellness to the highest level possible for each client.

It is the philosophy of case management that when the provision of health care is effective and efficient, all parties benefit. Case management, provided as part of a collaborative and interprofessional health care team, serves to identify options and resources which are acceptable to the client and client's family or family caregiver. This then, in turn, increases the potential for effective client's engagement in self-management, adherence to the case management plan of care, and the achievement of successful outcomes.

Case management interventions focus on improving care coordination and reducing the fragmentation of the services the recipients of care often experience especially when multiple health care providers and different care settings are involved. Taken collectively, case management interventions are intended to enhance client safety, well-being, and quality of life. These interventions carefully consider health care costs through the professional case manager's recommendations of cost-effective and efficient alternatives for care. Thus, effective case management directly and positively impacts the health care delivery system especially in realizing the goals of the "Triple Aim" which include improving the health outcomes of individuals and populations, enhancing the experience of health care, and reducing the cost of care.

B. Guiding Principles

Guiding principles are relevant and meaningful concepts that clarify or guide practice. Guiding principles for case management practice provide that professional case managers:

- Use a client-centric, collaborative part-nership approach that is responsive to the individual client's culture, preferences, needs, and values.
- Facilitate client's self-determination and self-management through the tenets of advocacy, shared and informed decision-making, counseling, and health education, whenever possible.
- Use a comprehensive, holistic, and compassionate approach to care delivery which integrates a client's medical, behavioral, social, psychological, functional, and other needs.
- Practice cultural and linguistic sensitivity, and maintain current knowledge of diverse populations within their practice demographics.
- Implement evidence-based care guidelines in the care of clients, as available and applicable to the practice setting and/or client population served.
- Promote optimal client safety at the individual, organizational, and community level.
- Promote the integration of behavioral change science and principles throughout the case management process.
- Facilitate awareness of and connections with community supports and resources.
- Foster safe and manageable navigation through the health care system to enhance the client's timely access to services and the achievement of successful outcomes.

- Pursue professional knowledge and practice excellence and maintain competence in case management and health and human service delivery.
- Support systematic approaches to quality management and health outcomes improvement, implementation of practice innovations, and dissemination of knowledge and practice to the health care community.
- Maintain compliance with federal, state, and local rules and regulations, and organizational, accreditation, and certification standards.
- Demonstrate knowledge, skills, and competency in the application of case management standards of practice and relevant codes of ethics and professional conduct.

Case management guiding principles, interventions, and strategies target the achievement of optimal wellness, function, and autonomy for the client and client's family or family caregiver through advocacy, assessment, planning, communication, health education, resource management, care coordination, collaboration, and service facilitation.

The professional case manager applies these principles into practice based on the individualized needs and values of the client to assure, in collaboration with the interprofessional health care team, the provision of safe, appropriate, effective, client-centered, timely, efficient, and equitable care and services.

V. Case Management Practice Settings

Professional case management practice extends to all health care settings across the continuum of health and human services. This may include the payer, provider, government, employer, community, and client's home environment. The practice varies in degrees of complexity, intensity, urgency and comprehensiveness based on the following four factors (Powell and Tahan, 2008; Tahan and Treiger, 2017):

1. The context of the care setting such as wellness and prevention, acute, subacute and rehabilitative, skilled care, or end-of-life.
2. The health conditions and needs of the client population(s) served, and the needs of the client's family or family caregivers.
3. The reimbursement method applied, such as managed care, workers' compensation, Medicare, or Medicaid.
4. The health care professional discipline of the designated case manager such as but not limited to a registered nurse, social worker, physician, rehabilitation counselor, and disability manager.

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

- Hospitals and integrated care delivery systems, including acute care, sub-acute care, long-term acute care (LTAC) facilities, skilled nursing facilities (SNFs), and rehabilitation facilities.
- Ambulatory care clinics and community-based organizations, including student or university counseling and health care centers, medical and health homes, primary

care practices, and federally qualified health centers.
- Corporations.
- Schools.
- Public health insurance and benefit programs such as Medicare, Medicaid, and state-funded programs.
- Private health insurance programs such as workers' compensation, occupational health, catastrophic and disability management, liability, casualty, automotive, accident and health, long-term care insurance, group health insurance, and managed care organizations.
- Independent and private case management companies.
- Government-sponsored programs such as correctional facilities, military health and Veterans Administration, and public health.
- Provider agencies and community-based facilities such as mental/behavioral health facilities, home health services, ambulatory, and day care facilities.
- Geriatric services, including residential, senior centers, assisted living facilities, and continuing care retirement communities.
- Long-term care services, including home, skilled, custodial, and community based programs.
- End-of-Life, hospice, palliative, and respite care programs.
- Physician and medical group practices, Patient Centered Medical Home (PCMH), Accountable Care Organizations (ACOs), and Physician Hospital Organizations (PHOs).
- Life care planning programs.
- Population health, wellness and prevention programs, and disease and chronic care management companies.

VI. Professional Case Management Roles and Responsibilities

It is necessary to differentiate between the terms "role," "function," and "activity" before describing the responsibilities of professional case managers. Defining these terms provides a clear and contextual understanding of the roles and responsibilities of case managers in the various practice settings.

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 or a set of specific tasks or activities within the role. An activity is a discrete action, behavior or task a person performs to address the expectations of the role assumed (Tahan and Campagna, 2010).

A role consists of several functions and each function is described through a list of specific and related activities. These descriptions constitute what is commonly known as a "job description" (Tahan and Campagna, 2010). The roles professional case managers assume may vary based on the same four factors described earlier in the section entitled, Case Management Practice Settings.

The professional case manager performs the primary functions of assessment, planning, facilitation, coordination, monitoring, evaluation, and advocacy. Integral to these functions is collaboration and ongoing communication with the client, client's family or family caregiver, and other health care professionals involved in the client's care. Nationally recognized professional associations and specialty certifying bodies have identified key responsibilities of case managers through expert opinions, practice analyses, and roles and functions research.

It is not the intent of the *Standards of Practice for Case Management* to parallel these key responsibilities. The Standards broadly define major functions involved in the case management process to achieve desired outcomes. The specific roles and responsibilities of professional case managers may vary based on their health discipline background and the environment or care setting they practice in.

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

To facilitate effective and competent performance, the professional case manager should demonstrate knowledge of health insurance and funding sources, health care services, human behavior dynamics, health care delivery and financing systems, community resources, ethical and evidence-based practice, applicable laws and regulations, clinical standards and outcomes, and health information technology and digital media relevant to case management practice. The skills and knowledge base of a professional case manager may be applied to individual clients such as in the hospital setting, or to groups of clients such as in disease, chronic care, or population health management models. Often case managers execute their responsibilities across settings, providers, over time, and beyond the boundaries of a single episode of care. They also employ the use of health and information technology and tools.

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

- Considering predictive modeling, screening, and other data, where appropriate, in deciding whether a client would benefit from case management services.
- Conducting an assessment of the client's health, physical, functional, behavioral, psychological, and social needs, including health literacy status and deficits, self-management abilities and engagement in taking care of own health, availability of psychosocial support systems including family caregivers, and socioeconomic background. The assessment leads to the development and implementation of a client-specific case management plan of care in collaboration with the client and family or family caregiver, and other essential health care professionals.
- Identifying target care goals in collaboration with the client, client's family or family caregiver, and other members of the health care team. Securing client's agreement on the target goals and desired outcomes.
- Planning the care interventions and needed resources with the client, family or family caregiver, the primary care provider, other health care professionals, the payer, and the community-based agents, to maximize the client's health care responses, quality, safety, cost-effective outcomes, and optimal care experience.
- Facilitating communication and coordination among members of the interprofessional health care team, and involving the client in the decision-making process in order to minimize fragmentation in the services provided and prevent the risk for unsafe care and suboptimal outcomes.
- Collaborating with other health care professionals and support service providers across care settings, levels of care, and professional disciplines, with special attention to safe transitions of care.
- Coordinating care interventions, referrals to specialty providers and community-based support services, consults, and resources across involved health providers and care settings.
- Communicating on an ongoing basis with the client, client's family or family caregiver, other involved health care professionals and support service providers, and assuring that all are well-informed and current on the case management plan of care and services.
- Educating the client, the family or family caregiver, and members of the interprofessional health care team about treatment options, community resources, health insurance benefits, psychosocial and financial concerns, and case management services, in order to make timely and informed care-related decisions.
- Counseling and empowering the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.
- Completing indicated notifications for and pre-authorizations of services, medical necessity reviews, and concurrent or retrospective communications, based on payer's requirements and utilization management procedures.
- Ensuring the appropriate allocation, use, and coordination of health care services and resources while striving to improve safety and quality of care, and maintain cost effectiveness on a case-by-case basis.
- Identifying barriers to care and client's engagement in own health; addressing these barriers to prevent suboptimal care outcomes.
- Assisting the client in the safe transitioning of care to the next most appropriate level, setting, and/or provider.
- Striving to promote client self-advocacy, independence, and self-determination, and the provision of client-centered and culturally-appropriate care.

- Advocating for both the client and the payer to facilitate positive outcomes for the client, the interprofessional health care team, and the payer. However, when a conflict arises, the needs of the client must be the number one priority.
- Evaluating the value and effectiveness of case management plans of care, resource allocation, and service provision while applying outcomes measures reflective of organizational policies and expectations, accreditation standards, and regulatory requirements.
- Engaging in performance improvement activities with the goal of improving client's access to timely care and services, and enhancing the achievement of target goals and desired outcomes.

VII. Components of the Case Management Process

The case management process is carried out within the ethical and legal realms of a case manager's scope of practice, using critical thinking and evidence-based knowledge. The overarching themes in the case management process include the activities described below.

Note that the case management process is cyclical and recurrent, rather than linear and unidirectional. For example, key functions of the professional case manager, such as communication, facilitation, coordination, collaboration, and advocacy, occur throughout all the steps of the case management process and in constant contact with the client, client's family or family caregiver, and other members of the interprofessional health care team. Primary steps in the case management process include:

1. Client Identification, Selection and Engagement in Professional Case Management:

- Focus on screening clients identified or referred by other professionals for case management to determine appropriateness for and benefits from services.
- Engagement of the client and family or family caregiver in the process.
- Obtaining consent for case management services as part of the case initiation process.

2. Assessment and Opportunity Identification:

- Assessment begins after screening, identification and engagement in case management. It involves data gathering, analysis, and synthesis of information for the purpose of developing a client-centric case management plan of care.
- Assessment helps establish the client-case manager's relationship and the client's readiness to engage in own health and well-being. It requires the use of effective communication skills such as active listening, meaningful conversation, motivational interviewing, and use of open-ended questions.
- Care needs and opportunities are identified through analysis of the assessment findings and determination of identified needs, barriers, and/or gaps in care.
- Assessment is an ongoing process occurring intermittently, as needed, to determine efficacy of the case management plan of care and client's progress toward achieving target goals.
- Assessment should cover medical, behavioral health, substance use and abuse and social determinants of health.

3. Development of the Case Management Plan of Care:

- The case management plan of care is a structured, dynamic tool used to document the opportunities, interventions, and expected goals, the professional case manager applies during the client's engagement in case management services. It includes:
  - Identified care needs, barriers and opportunities for collaboration with the client, family and/or family caregiver, and members of the interprofessional care team in order to provide more effective integrated care;
  - Prioritized goals and/or outcomes to be achieved; and
  - Interventions or actions needed to reach the goals.
- Client and/or client's family or family caregiver input and participation in the development of the case management plan of care is essential to promote client-centered care and maximize potential for achieving the target goals.

4. **Implementation and Coordination of the Case Management Plan of Care:**

- The case management plan of care is put into action by facilitating the coordination of care, services, resources, and health education specified in the planned interventions.
- Effective care coordination requires ongoing communication and collaboration with the client and/or client's family or family caregiver, as well as the provider and the entire interprofessional health care team.

5. **Monitoring and Evaluation of the Case Management Plan of Care:**

- Ongoing follow-up with the client, family and/or family caregiver and evaluation of the client's status, goals, and outcomes.

- Monitoring activities include assessing client's progress with planned interventions
- Evaluating if care goals and interventions remain appropriate, relevant, and realistic.
- Determining if any revisions or modifications are needed to the care needs, goals, or interventions specified in the client's case management plan of care.

6. **Closure of the Professional Case Management Services:**

- Bringing mutually-agreed upon closure to the client-case manager relationship and engagement in case management.
- Case closure focuses on discontinuing the professional case management services when the client has attained the highest level of functioning and recovery, the best possible outcomes, or when the needs and desires of the client have changed.

VIII. Standards of Professional Case Management Practice

A. STANDARD: CLIENT SELECTION PROCESS FOR PROFESSIONAL CASE MANAGEMENT SERVICES

The professional case manager should screen clients referred for case management services to identify those who are appropriate for and most likely to benefit from case management services available within a particular practice setting.

How Demonstrated:

- Documentation of consistent use of the client selection process within the organization's policies and procedures.
- Use of screening criteria as appropriate to select a client for inclusion in case management. Examples of screening criteria may include, but are not limited to:

  - Barriers to accessing care and services
  - Advanced age
  - Catastrophic or life-altering conditions
  - Chronic, complex, or terminal conditions
  - Concerns regarding self-management ability and adherence to health regimens
  - Developmental disabilities
  - End-of-life or palliative care
  - History of abuse or neglect
  - History of mental illness, substance use, suicide risk, or crisis intervention
  - Financial hardships
  - Housing and transportation needs
  - Lack of adequate social support including family caregiver support
  - Low educational levels
  - Low health literacy, reading literacy, or numeracy literacy levels
  - Impaired functional status and/or cognitive deficits
  - Multiple admissions, readmissions, and emergency department (ED) visits
  - Multiple providers delivering care and/or no primary care provider
  - Polypharmacy and medication adherence needs
  - Poor nutritional status
  - Poor pain control
  - Presence of actionable gaps in care and services
  - Previous home health and durable medical equipment usage
  - Results of established predictive modeling analysis and/or health risk screening tools indicative of need for case management
  - Risk taking behaviors

- Recognition that a professional case manager may receive pre-screened client referrals from various sources, including (but not limited to) direct referrals from health care professionals and system-generated flags, alerts, or triggers. In these situations, the case manager should document the referral source and why the client is appropriate for case management services.

B. STANDARD: CLIENT ASSESSMENT

The professional case manager should complete a thorough individualized client centered assessment that takes into account the unique cultural and linguistic needs of that client including client's family or family caregiver as appropriate.

It is recognized that an assessment:

- is a process, that focuses on evolving client needs identified by the case manager over the duration of the professional relationship and across the transitions of care;
- involves each client and/or the client's family or family caregiver as appropriate, and;
- is inclusive of the medical, cognitive, behavioral, social, and functional domains, as pertinent to the practice setting (Kathol, Perez, & Cohen, 2010) the client uses to

access care.

How Demonstrated:

- Documented client assessments using standardized tools, both electronic and written, when appropriate. The assessment may include, but is not limited to the following components:

  ### Medical

  - Presenting health status and conditions
  - Medical history including use of prescribed or over the counter medications and herbal therapies
  - Relevant treatment history
  - Prognosis
  - Nutritional status

  ### Cognitive and Behavioral

  - Mental health
    - History of substance use
    - Depression risk screening
    - History of treatment including prescribed or over the counter medications and herbal therapies
  - Cognitive functioning
    - Language and communication preferences, needs, or limitations
  - Client strengths and abilities
    - Self-care and self-management capability
    - Readiness to change
  - Client professional and educational focus
    - Vocational and/or educational interests
    - Recreational and leisure pursuits
  - Self-Management and Engagement Status
    - Health literacy
    - Health activation level
    - Knowledge of health condition
    - Knowledge of and adherence to plan of care
    - Medication management and adherence

    - Learning and technology capabilities

  ### Social

  - Psychosocial status:
    - Family or family caregiver dynamics
    - Caregiver resources: availability and degree of involvement
    - Environmental and residential
  - Financial Circumstances
  - Client beliefs, values, needs, and preferences including cultural and spiritual
  - Access to care
    - Health insurance status and availability of health care benefits
    - Health care providers involved in client's care
    - Barriers to getting care and resources
  - Safety concerns and needs
    - History of neglect, abuse, violence, or trauma
    - Safety of the living situation
  - Advanced directives planning and availability of documentation
  - Pertinent legal situations (e.g. custody, marital discord, and immigration status)

  ### Functional

  - Client priorities and self-identified care goals
  - Functional status
  - Transitional or discharge planning needs and services, if applicable
    - Health care services currently receiving or recently received in the home setting
    - Skilled nursing, home health aide, durable medical equipment (DME), or other relevant services
    - Transportation capability and constraints
    - Follow-up care (e.g., primary care, specialty care, and appointments)
    - Safety and appropriateness of home or residential environment

- Reassessment of the client's condition, response to the case management plan of care and interventions, and progress toward achieving care goals and target outcomes.
- Documentation of resource utilization and cost management, provider options, and available health and behavioral care benefits.
- Evidence of relevant information and data required for the client's thorough assessment and obtained from multiple sources including, but not limited to:
  - Client interviews;
  - Initial and ongoing assessments and care summaries available in the client's health record and across the transitions of care;
  - Family caregivers (as appropriate), physicians, providers, and other involved members of the interprofessional health care team;
  - Past medical records available as appropriate; and
  - Claims and administrative data.

C. STANDARD:
CARE NEEDS AND OPPORTUNITIES IDENTIFICATION

The professional case manager should identify the client's care needs or opportunities that would benefit from case management interventions.

How Demonstrated:

- Documented agreement among the client and/or client's family or family caregiver, and other providers and organizations regarding the care needs and 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 and resources
- Use of multiple providers and/or agencies
- Lack of integrated care
- Use of inappropriate services or level of care
- Lack of a primary provider or any provider
- Non-adherence to the case management plan of care (e.g. medication adherence) which may be associated with the following:
  - Low reading level
  - Low health literacy and/or numeracy
  - Low health activation levels
  - Language and communication barriers
- Lack of education or understanding of:
  - Disease process
  - Current condition(s)
  - The medication list
  - Substance use and abuse
  - Social determinants of health
- Lack of ongoing evaluation of the client's limitations in the following aspects of health condition:
  - Medical
  - Cognitive and Behavioral
  - Social
  - Functional
- Lack of support from the client's family or family caregiver especially when under stress
- Financial barriers to adherence of the case management 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 condition or

needs
- Frequent transitions between care settings or providers
- Poor or no coordination of care between settings or providers

D. STANDARD: PLANNING

The professional case manager, in collaboration with the client, client's family or family caregiver, and other members of the interprofessional health care team, where appropriate, should identify relevant care goals and interventions to manage the client's identified care needs and opportunities. The case manager should also document these in an individualized case management plan of care.

How Demonstrated:

- Documented relevant, comprehensive information and data using analysis of assessment findings, client and/or client's family or family caregiver interviews, input from the client's interprofessional health care team, and other methods as needed to develop an individualized case management plan of care.
- Documented client and/or client's family or family caregiver participation in the development of the written case management plan of care.
- Documented client agreement with the case management plan of care, including agreement with target goals, expected outcomes, and any changes or additions to the plan.
- Recognized client's needs, preferences, and desired role in decision-making concerning the development of the case management plan of care.
- Validated that the case management plan of care is consistent with evidence-based practice, when such guidelines are available and applicable, and that it continues to meet the client's changing needs and health condition.
- Established measurable goals and outcome

indicators expected to be achieved within specified time frames. These measures could include clinical as well as non-clinical domains of outcomes management. For example, access to care, cost-effectiveness of care, safety and quality of care, and client's experience of care.
- Evidence of supplying the client, client's family, or family caregiver with information and resources necessary to make informed decisions.
- Promoted awareness of client care goals, outcomes, resources, and services included in the case management plan of care.
- Adherence to payer expectations with respect to how often to contact and reevaluate the client, redefine long and short term goals, or update the case management plan of care.

E. STANDARD: MONITORING

The professional case manager should employ ongoing assessment with appropriate documentation to measure the client's response to the case management plan of care.

How Demonstrated:

- Documented ongoing collaboration with the client, family or family caregiver, providers, and other pertinent stakeholders, so that the client's response to interventions is reviewed and incorporated into the case management plan of care.
- Awareness of circumstances necessitating revisions to the case management plan of care, such as changes in the client's condition, lack of response to the case management interventions, change in the client's preferences, transitions across care settings and/or providers, and barriers to care and services.
- Evidence that the plan of care continues to be reviewed and is appropriate, understood, accepted by client and/or client's family or family caregiver, and documented.
- Ongoing collaboration with the client,

family or family caregiver, providers, and other pertinent stakeholders regarding any revisions to the plan of care.

F. STANDARD: OUTCOMES

The professional case manager, through a thorough individualized client-centered assessment, should maximize the client's health, wellness, safety, physical functioning, adaptation, health knowledge, coping with chronic illness, engagement, and self-management abilities.

How Demonstrated:

- Created a case management plan of care based on the thorough individualized client-centered assessment.
- Achieved through quality and cost-efficient case management services, client's satisfaction with the experience of care, shared and informed decision-making, and engagement in own health and health care.
- Evaluated the extent to which the goals and target outcomes documented in the case management plan of care have been achieved.
- Demonstrated efficacy, efficiency, quality, safety, and cost-effectiveness of the professional case manager's interventions in achieving the goals documented in the case management plan of care and agreed upon with the client and/or client's family caregiver.
- Measured and reported impact of the case management plan of care.
- Applied evidence-based adherence guidelines, standardized tools and proven care processes. These can be used to measure the client's preference for, and understanding of:
  - The proposed case management plan of care and needed resources;
  - Motivation to change and demonstrate healthy lifestyle behavior; and
  - Importance of availability of engaged client, family or family caregiver.

- Applied evidence-based guidelines relevant to the care of specific client populations.
- Evaluated client and/or client's family or family caregiver experience with case management services.
- Used national performance measures for transitional care and care coordination such as those endorsed by the regulatory, accreditation, and certification agencies, and health-related professional associations to ultimately enhance quality, efficiency and optimal client experience.

G. STANDARD: CLOSURE OF PROFESSIONAL CASE MANAGEMENT SERVICES

The professional case manager should appropriately complete closure of professional case management services based upon established case closure guidelines. The extent of applying these guidelines may differ in various case management practice and/or care settings.

How Demonstrated:

- Achieved care goals and target outcomes, including those self-identified by the client and/or client's family or family caregiver.
- Identified reasons for and appropriateness of closure of case management services, such as:
  - Reaching maximum benefit from case management services;
  - Change of health care setting which warrants the transition of the client's care to another health care provider(s) and/or setting;
  - The employer or purchaser of case management services requests the closure of case management;
  - Services no longer meet program or benefit eligibility requirements;
  - Client refuses further case management services;
  - Determination by the professional case manager that he/she is no longer able

to provide appropriate case management services because of situations such as a client's ongoing disengagement in self-management and unresolved non-adherence to the case management plan of care;

- Death of the client;
- There is a conflict of interest; and
- When a dual relationship raises ethical concerns.
- Evidence of agreement for closure of case management services by the client, family or family caregiver, payer, professional case manager, and/or other appropriate parties.
- Evidence that when a barrier to closure of professional case management services arises, the case manager has discussed the situation with the appropriate stakeholders and has reached agreement on a plan to resolve the barrier.
- Documented reasonable notice for closure of professional case management services and actual closure that is based upon the facts and circumstances of each individual client's case and care outcomes supporting case closure. Evidence should show verbal and/or written notice of case closure to the client and other directly involved health care professionals and support service providers.
- Evidence of client education about service and/or funding resources provided by the professional case manager to address any further needs of the client upon case closure.
- Completed transition of care handover to health care providers at the next level of care, where appropriate, with permission from client, and inclusive of communication of relevant client information and continuity of the case management plan of care to optimize client care outcomes.

H. STANDARD:
FACILITATION, COORDINATION, AND COLLABORATION

The professional case manager should facilitate coordination, communication, and collaboration with the client, client's family or family caregiver, involved members of the interprofessional health care team, and other stakeholders, in order to achieve target goals and maximize positive client care outcomes.

How Demonstrated:

- Recognition of the professional case manager's role and practice setting in relation to those of other providers and organizations involved in the provision of care and case management services to the client.
- Developing and sustaining proactive client-centered relationships through open communication with the client, client's family or family caregiver, and other relevant stakeholders, to maximize outcomes and enhance client's safety and optimal care experience.
- Evidence of facilitation, coordination, and collaboration to support the transitions of care, including:
  - Transfers of clients to the most appropriate health care provider or care setting are coordinated in a timely and complete manner.
  - Documentation reflective of the collaborative and transparent communication between the professional case manager and other health care team members, especially during each transition to another level of care within or outside of the client's current setting.
  - Use of the case management plan of care, target goals, and client's needs and preferences to guide the facilitation and coordination of services and collaboration among members of the interprofessional health care team, client and client's family or family caregiver.
- Adherence to client privacy and confidentiality mandates during all aspects of

facilitation, coordination, communication, and collaboration within and outside the client's care setting.

- Use of special techniques and strategies such as motivational interviewing, mediation, and negotiation, to facilitate transparent communication and building of effective relationships.
- Coordination and implementation of the use of problem-solving skills and techniques to reconcile potentially differing points of view.
- Evidence of collaboration that optimizes client outcomes; this may include working with community, local and state resources, primary care providers, members of the interprofessional health care team, the payer, and other relevant stakeholders.
- Evidence of collaborative efforts to maximize adherence to regulatory and accreditation standards within the professional case manager's practice and employment setting.

I. STANDARD: QUALIFICATIONS FOR PROFESSIONAL CASE MANAGERS

The professional case manager should maintain competence in her/his 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 who practices 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 professional case manager's area(s) of practice.
- Compliance with national, state, and/or local laws and regulations that apply to the jurisdiction(s) and discipline(s) in which the professional case manager practices.
- Maintenance of competence through participation in relevant and ongoing continuing education, certification, academic study, and internship programs.
- Practicing within the professional case manager's area(s) of expertise, making timely and appropriate referrals to, and seeking consultation with, others when needed.

Supervision

The professional case manager acts in a supervisory and/or leadership role of other personnel who are unable to function independently due to limitations of license and/or education.

Due to the variation in academic degrees and other educational requirements, it is recommended that individuals interested in pursuing a professional case management career seek guidance as to the appropriate educational preparation and academic degree necessary to practice case management. These interested individuals may seek the Case Management Society of America, American Nurses Association, or Commission for Case Manager Certification, or other relevant professional organizations for further advice and guidance.

NOTE: *Social workers who are prepared at the*

Master's in Social Work (MSW) degree level and educated under a program that would preclude them from sitting for licensure (where required) or practice at the clinical level should consult with their state licensing board to determine if additional education and/or practicum hours are required.

J. STANDARD: LEGAL

The professional case manager shall adhere to all applicable federal, state, and local laws and regulations, which have full force and effect of law, governing all aspects of case management practice including, but not limited to, client privacy and confidentiality rights. It is the responsibility of the professional case manager to work within the scope of his/her license and/or underlying profession.

NOTE: *In the event that the professional case manager's employer policies or those of other entities are in conflict with applicable legal requirements, the case manager should understand that the law prevails. In these situations, case managers should seek clarification of questions or concerns from an appropriate and reliable expert resource, such as a legal counsel, compliance officer, or an appropriate government agency.*

1. Standard: Confidentiality and Client Privacy

The professional case manager should adhere to federal, state, and local laws, as well as policies and procedures, governing client privacy and confidentiality, and should act in a manner consistent with the client's best interest in all aspects of communication and recordkeeping whether through traditional paper records and/or electronic health records (EHR).

NOTE: *Federal law preempts (supersedes) state and local law and provides a minimum mandatory national standard; states may enlarge client rights, but not reduce them. For those who work exclusively on federal enclaves or on tribal lands, any issues of concern should direct them to the licensing authority and/or federal law.*

How Demonstrated:

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

2. Standard: Consent for Professional Case Management Services

The professional case manager should obtain appropriate and informed consent before the implementation of case management services.

How Demonstrated:

- Evidence that the client and/or client's family or family caregiver have been thoroughly informed with regard to:
  - Proposed case management process and services relating to the client's health condition(s) and needs;
  - Possible benefits and costs of such services;
  - Alternatives to proposed services;
  - Potential risks and consequences of proposed services and alternatives; and
  - Client's right to decline the proposed case management services and awareness of potential risks and consequences of such decision.
- Evidence that the information was communicated in a client-sensitive manner, which is intended to permit the client to make voluntary and informed choices.
- Documented informed consent where client consent is a prerequisite to the provision of case management services.

K. STANDARD: ETHICS

The professional case manager should behave and practice ethically, and adhere to the tenets of the code of ethics that underlie her/his professional credentials (e.g., nursing, social work, and rehabilitation counseling).

How Demonstrated:

- Awareness of the five basic ethical principles and how they are applied. These are:
    - Beneficence (to do good),
    - Nonmaleficence (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 primary obligation is to the clients cared for, with
    - A secondary obligation is engagement in and maintenance of respectful relationships with coworkers, employers, and other professionals.
    - Laws, rules, policies, insurance benefits, and regulations are sometimes in conflict with ethical principles. In such situations, the professional case manager is bound to address the conflicts to the best of her/his abilities and/or seek appropriate consultation.
    - All clients are unique individuals and the professional case manager engages them without regard to gender identity, race or ethnicity, and practice, religious, other cultural preferences, or socioeconomic status.
- Maintained policies that are universally respectful of the integrity and worth of each person.

L. STANDARD: ADVOCACY

The professional case manager should advocate for the client, client's family or family caregiver, at the service delivery, benefits administration, and policy-making levels. The case manager is uniquely positioned as an expert in care coordination and advocacy for health policy change to improve access to quality, safe, and cost-effective services.

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.
    - Facilitation of client access to necessary and appropriate services while educating the client and family or family caregiver about resource availability within practice settings.
    - Recognition, prevention, and elimination of disparities in accessing high-quality care and experiencing optimal client health care outcomes, as related to race, ethnicity, national origin, and migration background; sex and marital status; age, religion, and political belief; physical, mental, or cognitive disability; 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.
- Ensuring a culture of safety by engagement in quality improvement initiatives in the workplace.
- Encouraging the establishment of client, family and/or family caregiver advisory councils to improve client-centered care standards within the organization.
- Joining relevant professional organizations in call to action campaigns, whenever

possible, to improve the quality of care and reduce health disparities.

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

M. STANDARD: CULTURAL COMPETENCY

The professional case manager should maintain awareness of and be responsive to cultural and linguistic diversity of the demographics of her/his work setting and to the specific client and/or caregiver needs.

How Demonstrated:

- Evidence of communicating in an effective, respectful, and sensitive manner, and in accordance with the client's cultural and linguistic context.
- Assessments, goal-setting, and development of a case management plan of care to accommodate each client's cultural and linguistic needs and preference of services.
- Identified appropriate resources to enhance the client's access to care and improve health care outcomes. These may include the use of interpreters and health educational materials which apply language and format demonstrative of understanding of the client's cultural and linguistic communication patterns, including but not limited to speech volume, context, tone, kinetics, space, and other similar verbal/non-verbal communication patterns.
- Pursuit of professional education to maintain and advance one's level of cultural competence and effectiveness while working with diverse client populations.

N. STANDARD: RESOURCE MANAGEMENT AND STEWARDSHIP

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

How Demonstrated:

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

- Documentation which reflects that the intensity of case management services rendered corresponds with the needs of the client.

O. STANDARD: PROFESSIONAL RESPONSIBILITIES AND SCHOLARSHIP

The professional case manager should engage in scholarly activities and maintain familiarity with current knowledge, competencies, case management-related research, and evidence-supported care innovations. The professional case manager should also identify best practices in case management and health care service delivery, and apply such in transforming practice, as appropriate.

How Demonstrated:

- Incorporation of current and relevant research findings into one's practice, including policies, procedures, care protocols or guidelines, and workflow processes, and as applicable to the care setting.
- Efficient retrieval and appraisal of research evidence that is pertinent to one's practice and client population served.
- Proficiency in the application of research-related and evidence-based practice tools and terminologies.
- Ability to distinguish peer-reviewed materials (e.g., research results, publications) and apply preference to such work in practice, as available and appropriate.

- Accountability and responsibility for own professional development and advancement.
- Participation in ongoing training and/ or educational opportunities (e.g., conferences, webinars, academic programs) to maintain and expand one's skills, knowledge and competencies.
- Participation in research activities which support quantification and definition of valid and reliable outcomes, especially those that demonstrate the value of case management services and their impact on the individual client and population health.
- Identification and evaluation of best practices and innovative case management interventions.
- Leveraging opportunities in the employment setting to conduct innovative performance improvement projects and formally report on their results.
- Dissemination, through publication and/ or presentation at conferences, of practice innovations, research findings, evidence-based practices, and quality or performance improvement efforts.
- Membership in professional case management-related associations and involvement in local, regional, or national committees and taskforces.
- Mentoring and coaching of less experienced case managers, other interprofessional health care team members, and providers.

XI. Acknowledgements

X. Glossary

Activity: A discrete action, behavior, 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 & Campagna, 2010).

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: (1) 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). (2) A "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time" (NQF, 2010, p.1).

Care Management: (1) 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, pg.162). (2) 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 to avoid unnecessary services by preventing health problems from escalating.

Care Plan: A document that "represents the synthesis and reconciliation of the multiple plans of care produced by each provider to address specific health concerns. It serves as a blueprint shared by all [health care team] participants to guide individual's care. As such, it provides the structure required to coordinate care across multiple sites, providers and episode of care" (Standards & Interoperability Longitudinal Coordination of Care Workgroup, 2012, pg.2).

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes (CMSA, 2016).

Case Management Plan of Care: A comprehensive plan that includes a statement of the client's care needs, opportunities, and goals determined upon a thorough assessment of the client; strategies to address these needs; and measurable outcomes to demonstrate resolution of the care needs and achievement of goals, the time frame, the resources available, and the desires and motivation of the client. The plan of care should address the multiple conditions the client suffers and the necessary involvement of providers and support service personnel within and across care settings.

Case Management Process: The manner in which case management functions are performed, including: client identification, selection and engagement in case management; assessment and opportunity identification; development of the case management plan of care including specification of care goals and target outcomes; implementation and coordination of the case management plan of care; monitoring and evaluation of the case management plan of care; closure of case management services.

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.

Chronic Care Management: An approach to care which encompasses the oversight of health and human service provision and education activities conducted by health care professionals to assist individuals with one or more chronic illnesses, such as diabetes, asthma, high blood pressure, heart failure, end stage renal disease, and HIV or AIDS, to understand their health condition and live productive lives. This approach involves motivating patients to become actively engaged in own health, adhere to necessary therapies and interventions, and achieve acceptable health outcomes including reasonable quality of life and well-being.

Chronic Care Management Services: Reimbursable care coordination services provided to Medicare beneficiaries with two or more chronic conditions which place the beneficiary at significant risk for death, acute exacerbation or functional decline; and require the implementation of comprehensive plans of care that are monitored over time. The services are accessible on a 24-hour-a-day, 7-day-a week basis and consist of at least 20 minutes of clinical staff time directed by a physician or another qualified health care professional during a calendar month. The services include systematic assessments of the beneficiary's medical, functional, and psychosocial needs; preventive services; a review of medication reconciliation, adherence, and self-management; and creation of client-centered care transitions (USDHHS - CMS, 2015a).

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, the term client may also infer the inclusion of the client's support. (2) Client can also imply the business relationship with a company which contracts or pays for case management services. The first definition is the one used throughout the Standards of Practice 2016.

Client Support System: The client's support system is defined by each client and may include biological relatives, a spouse, a partner, friends, neighbors, colleagues, a health care proxy, or any individual who supports the client.

Consumer: A 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 "client," "member," "enrollee," "beneficiary," "patient," "injured worker," "claimant," "college student", or "resident." 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 understand and 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, practices, courtesies, relationships, languages, manners, rituals and institutions of a racial, ethnic, religious, social, or political 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, T., Bazron, B., Dennis, K., & Isaacs, M., as cited in USDHHS, OMH, 2001).

Disease Management: A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. This system supports the physician or practitioner/client relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies; and evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health. 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 (Population Health Alliance, 2016).

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. Family members are not limited to blood relatives; they rather constitute any person the client wishes to designate as family or support system.

Family Caregiver: A "person who cares for relatives or loved ones. The care recipient may be a member of the caregiver's *family of origin*, or his or her *family of choice*, such as a friend, neighbor, support group member or life partner. In either instant, the term family caregiver… refers to a non-professional who provides unpaid care for others in the home" and usually such person is identified as the designated caregiver by the recipient of care her/himself (Emblem

Health & National Alliance for Caregiving, 2010, pg. 1).

Function: A grouping or a set of specific tasks within a 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 & Campagna, 2010).

Handover: sometimes referred to as handoff. The transfer of authority, responsibility and accountability for something to another individual. In the context of professional case management, handover refers to the transfer of authority, responsibility and accountability for the care of a client to another health care professional within or outside a health care setting as indicated based on the client's needs and care goals.

Health: In addition to the four definitions of "health" listed below (based on the World Health Organization's Key Policy Documents concerning Humanitarian Health Action-Definitions, retrieved from http://www.who.int/hac/about/definitions/en/ on May 23, 2016, 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 (World Health Organization, 1946).
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 (World Health Organization, 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 (Stokes, Noren, & Shindell, 1982).

4. A state of equilibrium between humans and the physical, biologic and social environment, compatible with full functional activity (Last, 1997).

Health Literacy: The degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions (USDHHS-HRSA, 2016).

Health Numeracy: The ability to access, use, interpret, and communicate mathematical and quantitative health information and ideas, to engage in and manage mathematical demands and computations in a range of situations (CDC, 2015).

Health Outcomes: Changes in current or future health status of individuals, groups, or communities that can be attributed to antecedent actions or measures (EURO European Centre for Health Policy, 1999). The change may be the result of a planned intervention or series of interventions, regardless of whether such an intervention was intended to change an individual's health status.

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

Interprofessional Health Care Team: (1) Health care professionals with complementary roles, knowledge, and skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable. (2) Relevant medical and allied health professionals coming together in a relational and client-centered approach to care provision where they collaboratively develop a client-centered case management plan of care and discuss care options and make joint decisions about the client's treatment and supportive

care plans, while considering the client's personal needs, preferences, and treatment options.

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 personnel. 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.

Patient Activation: also known as *client activation*. A behavioral concept that focuses on patient involvement and contributes to engagement. It is patient's knowledge, skills, ability, willingness, and confidence to manage own health and health care (Hibbard & Gilburt, 2014; Health Policy Brief, 2013).

Patient Engagement: also known as *client engagement*. "A broader concept that combines patient activation with interventions designed to increase activation and promote positive patient

behavior, such as obtaining preventive care or exercising regularly" (Health Policy Brief, 2013, pg.1). Patient engagement is known to increase patients' participation in informed and shared decision making regarding their care options and to improve health outcomes.

Payer: An individual or entity that funds related services, income, and/or products for an individual with health needs.

Plan of Care: *see Care Plan*. Some experts may refer to a plan of care to mean an individual clinician's plan to caring for a client with one or multiple conditions while a care plan is the integration of the plans designed by multiple providers to caring for a client with multiple conditions (Standards & Interoperability Longitudinal Coordination of Care Workgroup, 2012).

Predictive Modeling: Modeling is the process of mapping relationships among data elements that have a common thread. Through predictive modeling, data are "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. A role consists of several functions which constitute what is commonly known as a "job description." Each function in a role is described through a list of specific and related

activities. Usually, organizations and employers use a person's title as a proxy for her/his role; for example, "acute care case manager" (Tahan & Campagna, 2010).

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

Speech Kinetics: A communication pattern referring to the use of stance, gestures, eye behavior and other posturing by an individual in nonverbal communication.

Speech Space: A communication pattern referring to the physical distance or "comfort proximity" selected by an individual when communicating with another individual.

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 based on 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 client moves between one health care service provider and 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."

Value-Based Purchasing: A program provided by the Centers for Medicare & Medicaid Services as part of the Patient Protection and Affordable Care Act of 2010. This program rewards acute care hospitals with incentive payments based on the quality of care they provide to Medicare beneficiaries; how closely best clinical practices are followed; and how well the patient experience of care is enhanced (USDHHS - CMS, 2015b).

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CMSA
CASE MANAGEMENT SOCIETY OF AMERICA

CONTACT INFORMATION

CMSA National Office
6301 Ranch Drive
Little Rock, AR 72223

800.216.CMSA

TEL   501.225.2229
FAX   501.221.9068
EMAIL   cmsa@cmsa.org

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