CMSA™ Case Management Society of America

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Communicating Your Value: The Case Manager's Guide

POSITION PAPER

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FOREWORD

Professional case managers are healthcare professionals that serve as advocates to support, guide, and coordinate care for patients, families, and caregivers as they navigate their health and wellness journey (CMSA, 2022). Substantial research validates the profession's clinical, fiscal, and operational return on investment for populations and practice settings. Case management's value to healthcare industry stakeholders has been well-documented in the literature for over half a century.

Professional case management's fundamental strength lies in its interprofessional workforce. These individuals stand poised to assess and intervene with a trifecta of physical, behavioral, and psychosocial health priorities. Case managers are a coveted resource that are now embedded across the care continuum. Their footprints leave a trail through ambulatory and urgent care, community-based agencies, health plans, hospitals and other acute care settings, homecare, long-term care, and worker's compensation. Value-based payment models have influenced innovative case management models for children and adults with physical, developmental, and intellectual disabilities, persons with chronic illness, older adults, and individuals living with severe mental illness. These assorted specializations have contributed to a sizeable list of organizational accreditations, individual certifications, and credentials.

Robust definitions, standards of practice, and ethical codes and guidelines have been developed to reflect case management's expertise across the touchpoints of care. Each carefully crafted standard demonstrates a case manager's intrinsic importance. Qualifications are defined with ethical and legal parameters. Core practice behaviors are delineated, and anchored to defined competencies. Professional codes of conduct bolster case management's unique ethical foundation. Autonomy, beneficence, fidelity, justice, and nonmaleficence intersect with critical practice domains: accountability, advocacy, collaboration, client selection and assessment, coordination, cultural competence, facilitation, monitoring, health information technology, outcomes, professionalism, resource management, and closure (ACMA, 2020; CMSA, 2022). Case management utilizes intentional and methodical processes, generating resources which guide our practices.

The opportunities arising from case management's vast growth have led to confusion among industry stakeholders around the scope of each case manager's role. Patients and their families are routinely perplexed by the different focus of case managers they encounter, such as during a hospitalization versus a home health visit. It can be common for organizations to have multiple case management job descriptions for the same role across varied sites. Internal and external colleagues require a score card to keep pace with the intricacies of each case management department with their varied positions, and functions.

Despite case management's proven worth to the industry, it remains a necessity to quantify and qualify the profession's value across stakeholder groups. The continuous growth of case manager positions has yielded an unparalleled opportunity; development of a position paper to inform all stakeholders of case management's intrinsic worth.

Knowledge is power with professional case management's value among the most powerful and enduring resources for stakeholders. Using the profession's fiercest voices, this white paper provides an accurate map of how case managers across the industry heed the **Quintuple Aim** (Nundy, et al., 2022). They ensure quality-driven, patient- and family- centric care, rendered at the right time, at the right cost, with health equity at its core, by professionals who embrace the work. In doing do, case management's significant impact for all stakeholders is clearly inscribed in the annals of healthcare practice.

Ellen Fink-Samnick, DBH, MSW, LCSW, ACSW, CCM, CCTP, CRP, FCM

INTRODUCTION

As the complexity of healthcare systems grows, the ability to effectively navigate and coordinate care has become increasingly important. Case management is critical in ensuring the optimal delivery of services and support to patients. However, many case managers find it difficult to articulate and advocate the true value they bring to the healthcare industry as a whole and to their patients/clients. Recognizing that this issue needed to be addressed, the Case Management Society of America and The Center for Case Management have joined forces to create a position paper that begins to address this complex issue.

“Communicating Your Value: The Case Manager’s Guide” has experts from some of the most common specialty areas in case management share their knowledge in easily consumable guides. Each guide addresses roles and responsibilities as well as the value of case management in relation to the patient/family, organizations, colleagues, and the community. It is CMSA's and CfCM’s hope that this position paper empowers case managers to fully advocate their value and leads to a deeper discussion around the value of case management.

INPATIENT GUIDES

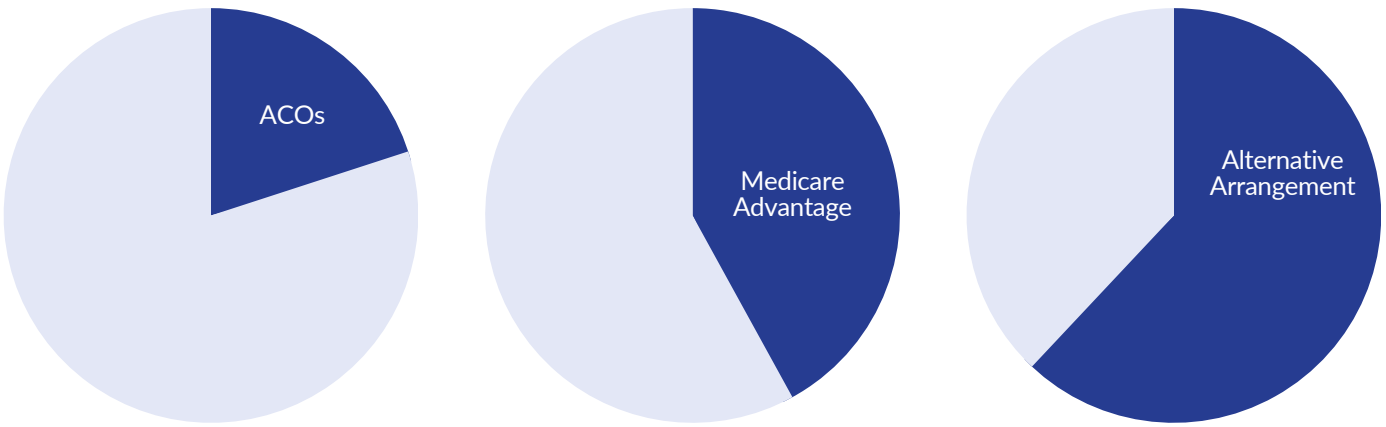
Accountable Care Organizations

Patricia O'Dea-Evans, MS, BSN, RN, LCPC, CCM

An Accountable Care Organization (ACO) is a healthcare delivery model designed to improve the coordination and quality of care while reducing overall costs. ACOs are formed by groups of healthcare providers, such as hospitals, physicians, and other healthcare professionals, who voluntarily come together to collaborate in delivering care to a defined group of patients, often Medicare beneficiaries. There are Medicare, Medicaid and Commercial ACOs.

With the Accountable Care Act in 2010, the ACO model has incrementally increased in use along with Medicare Advantage plans. In 2023, ACOs cover 20% of the Medicare population in the United States while 42% are enrolled in Medicare Advantage, with 62% of the Medicare population currently in an alternative arrangement (CMS, 2023) (Wilensky, 2022). Patients are assigned to ACOs by Medicare and may not even be aware that their physician is participating. They do get a letter informing them of the program and a letter is to be posted in the physician's office.

The Center for Medicare and Medicaid Services (CMS) encourages healthcare providers to participate in these payment arrangements (CMS, 2022). CMS has a goal of having all people in an accountable care provider relationship by 2030 (CMS, 2023). This projected growth is important to the case management profession as case managers play a key role in the success of ACOs.



% Medicare Population Coverage (2023)

ACOs are focused on the **"Quadruple Aim"** of healthcare and base their metrics on this framework. The Quadruple Aim is a healthcare framework focused on improving patient experiences and population health as well as reducing healthcare costs, while also addressing the well-being and satisfaction of healthcare providers and staff. The Quadruple Aim was introduced to create a more comprehensive and balanced approach to healthcare delivery.

The four aims are:

1. **Improving patient experience:** This aim focuses on enhancing the quality and satisfaction of patients' interactions with the healthcare system, ensuring that patients receive patient-centered, coordinated, and compassionate care.

2. **Improving population health:** The second aim is to improve the overall health of the population, not just individual patients. It involves focusing on preventive care, health promotion, and addressing social determinants of health to improve the health outcomes of communities.

3. **Reducing healthcare costs:** This emphasizes the need to control healthcare costs, making healthcare services more affordable and sustainable for individuals and the population.

4. **Enhancing the well-being of healthcare providers:** The fourth aim acknowledges the critical role healthcare providers play in delivering high-quality care. It involves promoting the well-being, satisfaction, and engagement of healthcare professionals to prevent burnout and support their ability to deliver excellent care.

Roles and Responsibilities

Being part of an ACO requires additional focus from case managers. While traditionally patient care focus has always attempted to be "payer agnostic," ACOs require attention to patients that are part of the ACO network. This is because keeping the patient in "network" services can enhance the health and fiscal outcomes for the identified population.

For example, Jane Doe saw her usual primary care doctor on Monday and a full panel of routine blood tests was ordered. However, the next day she fell and broke her hip, resulting in transfer to another hospital where her usual doctor does not have privileges. In this scenario, the emergency department (ED) will reorder the same panel of tests prior to Jane's orthopedic surgery. Post-operatively, Jane is discharged to a non-affiliated skilled nursing facility (SNF) with chances for errors and omissions in Jane's medical history and medication reconciliation at the time of transfer. If, instead, Jane were maintained within the same health system throughout her entire arc of care, it would enable care coordination which would increase the accuracy of her records, decrease adverse outcomes, minimize hand-offs and redundant testing, and reduce the over cost of care.

Case managers have a role in helping patients understand what benefits patients reap through better coordination of care, and how staying within one system for care can help them not only get better care, but also care at less cost to the patient and the payer.

Within an ACO, case managers also have a role in managing utilization resources, using motivational interview techniques to help patients manage chronic diseases, and working as advocates to help patients navigate the healthcare system. For an ACO to be effective, inpatient case management needs to work closely with community-based services to integrate care across the inpatient and outpatient settings, in order to make the healthcare system more effective at improving population health, which ultimately reduces costs.

Value to the Patient/Family

Research demonstrates that a combination of case managers using motivational interviewing techniques, transitional care management support, and direction to patients with chronic disease results in fewer hospitalizations for the Medicare population and a reduction in medical expense (Hewner, 2014).

One Health ACO in Nebraska was able to develop a highly successful ACO . They attribute their success to creating a culture of patient-centered primary care, and putting case managers in the primary care setting with the physicians (Rauner, 2023). The CM monitored every inpatient, ED, and SNF discharge, to ensure integrated continuity with outpatient services.

A Medicaid ACO in Minnesota developed a specialized case manager team and system for care to assist patients who were homeless with obtaining housing. This reduced calls from the shelter to 911, and decreased ED visits (National Health Care for the Homeless Council, May 2018).

Value to Colleagues

By incorporating the well-being of healthcare providers into the framework, the Quadruple Aim recognizes the importance of a healthy and motivated workforce in achieving the overall goals of the healthcare system. This framework has gained prominence as healthcare organizations strive to create healthier and more balanced work environments for their staff, while simultaneously improving patient outcomes and reducing costs. Case managers play an important role in determining an ACO's success; by influencing and coordinating care between providers. Transitions that are coordinated with help from case management are invaluable to all members of the internal and external care teams.

Value to the Organization

Research supports the effectiveness of case management in one study that looked at over 7,000 Medicaid recipients with hospitalization in 2013, they found fewer readmissions in an ACO population that used care managers. The study demonstrated the success of accountable care delivery models to "produce high-value healthcare utilization." They also found that patients who had more complex health comorbidities, and males, are most in need of continued intervention to reduce readmissions to the hospital (Hewner, et al., 2016).

In the inverse, when care transitions are poorly coordinated from the hospital to other care settings—costs are estimated between $12 billion to $44 billion per year. Poor transitions also result in poor health outcomes, such as injuries due to medication errors, complications post procedures, infections, and falls (CHRT, 2014). It is estimated that up to one-third of the more than $2.8 trillion spent on health in the United States each year is waste related largely to failures of care delivery, care coordination, and overuse (Clark, et al. 2017).

Value to the Community

Improving the overall health of the population, not just individual patients, is the goal of the ACO. However, broad population health outcomes are accomplished one patient at a time. Case management helps the ACO provide outreach for preventive care. It also helps address social determinants of health to improve the health outcomes of communities. ACOs overwhelmingly identify case management as a key component to improving health care delivery to an identified population, making case management a major component for the success of ACOs and their patients. Research has shown that case management is key to an ACO achieving its desired outcomes.

Metrics Representing Value:

The main metrics of an ACO are identified in the following categories:

- **Improved coordination of care:** ACOs aim to enhance communication and collaboration among healthcare providers involved in each patient's care. This ensures that patients receive the right care at the right time, avoiding unnecessary duplication of services or medical errors. Case managers are part of the strategy to help ACOs achieve positive outcomes.

- **Better quality of care:** ACOs focus on providing high-quality care and promoting preventive services to keep patients healthier, reducing the occurrence of more severe health issues. Case management is involved in the design and implementation of strategies to help patients engage in proactive care and improve the management of chronic disease to decrease the risk of progression to severe sequelae.

- **Cost savings**: By coordinating care and emphasizing preventive measures, ACOs strive to reduce healthcare costs, particularly by reducing the number of unnecessary hospital admissions and readmissions. CMS wants to shift from paying for volume to paying for value and outcomes (CMS, 2022).

- **Shared savings**: When an ACO achieves cost savings while maintaining or improving quality, it may be eligible to share in the savings generated with the Medicare program or other payers. For example, the largest CMS program, Medicare Shared Savings Program (MSSP), sets benchmarks for a participating ACO. If the ACO reaches the financial and quality benchmarks, Medicare reimburses the ACO fifty cents for every dollar saved.

ACOs typically use health information technology and data analytics to identify patients who need specific interventions and to track their progress over time. By doing so, ACOs can proactively manage patients' health, particularly those with chronic conditions, to keep them out of the hospital and reduce healthcare costs.

> "ACOs focus on providing high-quality care and promoting preventive services to keep patients healthier and prevent the development of more severe health issues."

Acute Care

Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM

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” (CMSA, 2022). The role of a professional case manager in an acute care setting is crucial and provides significant clinical value. Professional case managers are healthcare professionals (of multiple disciplines) who work with patients, their families, and the healthcare team to coordinate and ensure the delivery of comprehensive and effective care during the patient's hospitalization and beyond.

Roles and Responsibilities

CARE COORDINATION:

By overseeing the patient's care from admission to discharge, professional case managers in the acute care setting promote continuity of care. They help maintain consistency in treatment plans, medication management, and follow-up appointments, reducing the risk of medical errors and improving patient outcomes. Professional case managers assess the unique needs of each patient and work with the healthcare team to develop personalized care plans. This tailored approach ensures that the patient receives the most appropriate interventions and therapies for their specific condition. They act as the point of contact and coordination for all aspects of a patient's care, ensuring seamless communication between healthcare providers, specialists, and ancillary services–preventing gaps in care and ensuring that the patient's treatment plan is executed efficiently (Zimmerman, et al., 2021). Case managers also collaborate with external healthcare providers, including primary care physicians, specialists, home health agencies, and other community-based services. They share crucial information, treatment plans, and updates, ensuring that the patient receives consistent and coordinated care throughout their healthcare journey.

TRANSITION PLANNING:

An essential aspect of case management in the acute care setting is transition planning. Professional case managers work to prepare patients and their families for the transition from the hospital to other care settings, such as home care, rehabilitation facilities, or skilled nursing facilities. Professional case managers work closely with patients and their families to understand their unique needs, preferences, concerns and tailor transitional care plans and support services to address the specific challenges and goals of each patient; promoting a more personalized, holistic approach to care, thereby improving continuity of care throughout the patient's hospitalization and beyond. This level of care reduces disruptions in the patient's treatment plan. Case managers connect patients and families with valuable community resources and support services, such as support groups, counseling, and financial assistance programs, strengthening the patient's support system and helping them navigate challenges outside of the hospital setting.

ADVOCACY:

Case managers advocate for the patient's rights and preferences, ensuring that their values and beliefs are respected during the decision-making process. They encourage patients to actively participate in their care and make informed choices. They work closely with the patient and their family to foster a clear understanding of their medical condition, treatment options, and care plans, empowering them to make informed decisions about their health. Through the transition planning process, the professional case manager promotes the concept of patient choice, whether related to treatment plan, care setting or other options available.

Case managers advocate for the patient's psychosocial needs, ensuring that these aspects are not overlooked during treatment. They consider factors such as cultural beliefs, values, and preferences, and help the healthcare team understand and respect the patient's psychosocial context. They recognize the importance of familial and social support in a patient's recovery and work to strengthen these connections.

FINANCIAL:

The financial value of a professional case manager in an acute care setting can be substantial, as their role can positively impact various aspects of healthcare delivery, resource utilization, and patient outcomes. Professional case managers help optimize resource utilization in the acute care setting by identifying appropriate levels of care and coordinating services efficiently, contributing to cost-effective healthcare delivery. The professional case manager works with the patient and their family from a financial perspective through education regarding available insurance benefits, use of in-network versus out-of-network providers and associated costs/copays and promoting the concept of “right care, right setting, right time.”

Case managers in a Utilization Management role work with insurance companies and payers to ensure that services provided are appropriately documented and reimbursed through prevention of billing and coding errors, with a goal of timely and accurate reimbursement for healthcare services.

QUALITY:

By monitoring patient outcomes and analyzing data, professional case managers contribute to quality improvement initiatives in the acute care setting. They can identify areas for enhancement and implement evidence-based practices to enhance patient care. Professional case managers contribute to quality improvement initiatives within the healthcare facility. They collect data, analyze outcomes, and identify areas for improvement in patient care and care delivery processes (Driver, 2019). Professional case managers can contribute valuable insights to health data analysis. Their understanding of patients' conditions, barriers to care, and healthcare utilization patterns can inform health strategies and interventions.

Value to the Patient/Family

Case managers advocate for patients, ensuring their needs and preferences are considered, leading to a more positive healthcare experience. They facilitate clear communication between patients, families, and healthcare providers, reducing confusion and anxiety. Case managers educate patients and families about their conditions and care plans, empowering them to make informed decisions and participate in their care. By planning and coordinating post-discharge care, case managers promote a seamless transition from the hospital to home, reducing the risk of readmission. Case managers also provide emotional support and guidance during difficult times, helping patients and families cope with illness and treatment.

Value to the Organization

Case managers are vital in improving the quality of patient care, enhancing the organization's reputation and status in meeting accreditation and regulatory requirements.. They streamline care processes, reducing bottlenecks and improving workflow efficiency within the organization. Case managers help mitigate legal and ethical risks by ensuring that care is delivered in compliance with standards and regulations. High-quality case management can contribute to patient loyalty and retention, as patients are more likely to return to healthcare organizations that provide personalized, well-coordinated care.

Value to Colleagues

Case managers collaborate with healthcare teams, ensuring that all team members are aligned in delivering the best care possible. They handle administrative tasks related to care coordination, allowing clinicians to focus on clinical aspects of care. Case managers provide clinical support by monitoring patient progress, identifying issues, and facilitating timely interventions. Effective case management can improve job satisfaction among healthcare team members by reducing burnout and enhancing teamwork.

Case managers plan and coordinate post-discharge care and promote a seamless transition from hospital to home. They provide emotional support and guidance during difficult times, helping families cope.

Value to the Community

Addressing Social Determinants of Health

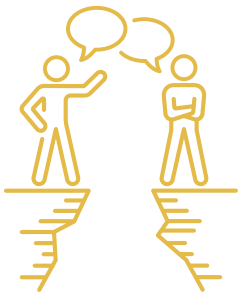
By helping patients access appropriate care and education, case managers contribute to the overall health and well-being of the community. Case managers work to reduce disparities in healthcare access and outcomes, promoting equity within the community. They engage in community outreach and education, promoting preventive healthcare measures and healthy lifestyles. Through cost-effective care coordination, case management can help control healthcare costs, benefiting the community by stabilizing healthcare expenses.

As the “masters of the social determinants of health,” professional case managers assess the social determinants of health that may impact a patient's well-being, such as housing stability, financial constraints, access to transportation, and social support systems. By addressing these factors, case managers contribute to better health outcomes and recovery (Fink-Samnick, 2019). Case managers collaborate with outpatient and community-based services to ensure a smooth transition of psychosocial care once the patient is discharged. This includes coordinating appointments with social workers, counselors, and community support organizations as needed.

Metrics Representing Value:
Common metrics tracked and reported by acute care case management departments include:

- **Length of Stay (LOS)** and LOS reduction through effective care coordination
- **30-day readmission rate**, identifying reasons for readmission and results from readmission reduction programs.
- **Patient satisfaction scores** (e.g., HCAHPS - Hospital Consumer Assessment of Healthcare Providers and Systems); especially related to "asking patients if they have help after discharge"
- **Resource utilization per patient** (e.g., lab tests, imaging studies, medications) and avoidable resource utilization (identifying unnecessary tests or treatments).
- **Cost savings** achieved through case management interventions and ROI (Return on Investment) of case management programs
- **Discharge Planning** metrics include reporting on the percentage of patients with documented discharge plans and timeliness of discharge planning
- **Ethical and Legal Compliance** and adherence to ethical standards and patient rights Compliance with Medicare compliance forms, Patient Choice regulations and Conditions of Participation.

In summary, the value of professional case managers in an acute care setting lies in their ability to facilitate coordinated, patient-centered care, improve patient outcomes, and enhance the overall efficiency and effectiveness of healthcare delivery. Case managers act as advocates for patients and help bridge the gap between different healthcare providers, ensuring a seamless and well-coordinated healthcare experience. By achieving these goals, professional case managers demonstrate their value in promoting positive patient outcomes, reducing healthcare costs, and providing comprehensive, patient-centered care in the acute care setting.



Case Managers act as advocates for patients and help bridge the gap between different healthcare providers, ensuring a seamless and well-coordinated healthcare experience.

Government/Military: Department of Veteran's Affairs

Francesca Bryan-Couch, DNP, RN, CHPN, CCM

The Department of Veterans Affairs (VA) is a co-located organization. This means that the majority of Veteran health care services may be located at a single VA location. Most VA facilities offer outpatient Primary Care, Specialty Care, Surgery, Mental Health, Social Work, Inpatient Medical Hospitalization, and Inpatient Mental Health services within a local VA Medical Center. Free-standing VA Outpatient Ambulatory Care Centers are also available within the VA healthcare system to provide services to Veterans not requiring hospitalization. The VA uses a consult-based system to request Veteran care. When a particular service is not available at the VA, the Veteran may choose to see a community health care provider or specialist.

Roles and Responsibilities

At the VA, case managers have academic degrees from various professional disciplines and provide services to Veterans in both the inpatient and outpatient settings, which include numerous medical and mental health treatment programs. Based on the VA-specific program requirements, case managers may have different roles, responsibilities, performance expectations, caseloads, and outcomes. VA case managers are licensed professionals such as registered nurses, social workers, psychologists, or therapists from other medical or behavioral health disciplines. All VA case managers follow the standards of practice within each professional licensure and discipline, as well as national case management standards of practice. Of note, one benefit of the VA healthcare system is that all members of the healthcare team have access to the Veteran's electronic health record and can participate in the case management decisions and activities.

According to Perla, Beck, and Grunberg (2023), VA case managers are advocates who assist Veterans in navigating complex VA and community health care systems to "align services, develop integrated care plans, and support team-based care." The process begins when a VA case manager receives a Veteran assignment to their panel. Basic care coordination and case management services are usually provided by the Primary Care nurse and/or social worker, with Veteran encounters a few times a year, for regular health maintenance visits or vaccinations.

Veterans with needs for moderate care coordination or case management are usually seen by a nurse or social worker who serves as the case manager in specialty care, telehealth, outpatient behavioral health, or other VA programs for which the Veteran meets eligibility criteria. Veterans with moderate care coordination needs may receive weekly to monthly case management interventions with the goal of helping the Veteran achieve self-management of medical or mental health conditions.

Veterans who have complex care coordination and case management needs are often assigned a dedicated case manager, called a Lead Coordinator. Lead Coordinators are usually experienced case managers with a background in nursing or social work plus specialized medical and/or behavioral health motivational interviewing skills. The VA has dedicated intensive case management programs, such as Military to VA (M2VA), Mental Health Integrated Case Management (MHICM), Home Based Primary Care (HBPC), and Housing and Urban Development-VA Supportive Housing (HUD-VASH).

The VA case manager evaluates the complexity of the Veteran's needs and then determines the intensity and frequency of Veteran encounters to provide evidence-based case management interventions. The Veteran is assessed to determine their needs—both from a biopsychosocial standpoint as well as their social determinants of health—in partnership with the Veteran. After the initial assessment of needs, Specific, Measurable, Achievable, Relevant, Time-bound (SMART) goals are developed to help the Veteran achieve the desired healthcare outcomes. The VA case manager will collaborate with other healthcare team members involved in the Veteran's care, to create a unified holistic care plan based on the Veteran's goals, values, and preferences and then will monitor the Veteran's progress toward achieving the healthcare goals. Case managers evaluate the effectiveness of the evidence-based treatments and interventions and will document all case management activities in the electronic health record.

If a Veteran is having difficulty progressing toward desired goals, the VA case manager may choose to schedule an interdisciplinary team (IDT) meeting to collaborate with other members of the health care team and discuss what other resources, services, or treatment options could be considered to help the Veteran achieve their healthcare goals. When the Veteran reaches desired health care goals, or when the Veteran is ready to transition to a different level of case management services, the primary case manager will provide a warm hand-off to the receiving case manager and include the Veteran in the conversation about the transition plan. The discussion will be documented in the electronic health record.

Value to the Patient/Family

Veterans choose to get medical and mental health services from the VA because VA healthcare is designed specifically for Veterans. Being a co-located organization has many benefits for patients, but it can also be very overwhelming for Veterans. The VA offers so many services, resources, and programs, that the Veteran may become lost and discouraged when requesting coordination of care. Nurses and social work case managers help Veterans navigate through the complexities of the VA health care system and Veterans have greater success in achieving healthcare goals when assigned a case manager.

Veterans who are assigned case managers experience better care coordination, have reduced use of non-urgent emergency services, have fewer hospitalizations, and experience better health outcomes. Better health outcomes increase patient satisfaction scores.

Value to the Organization

The VA has experienced the value of professional case management services provided to Veterans and their impact on the organization. When Veterans with moderate or complex health conditions receive proactive intensive case management interventions through a Lead Coordinator, the organization observes greater instances of cost avoidance. Higher levels of cost avoidance mean that healthcare leaders can reallocate unused resources to other areas of the organization.

Veterans with assigned case managers also tend to have better health outcomes. As a corollary, when VA case managers observe positive healthcare outcomes among their patients, they verbalize greater satisfaction with their own job. In turn, the VA experiences decreases in employee turnover and sick calls when case managers feel valued and see positive results on Veteran health care goals (Harter, 2023).

Value to Colleagues

Case management services are provided through multidisciplinary and supportive teams at the VA, which benefits the entire team. Case managers are members of specific program teams and members of larger healthcare department teams, which enables them to better coordinate care across various services. The VA has numerous resources and education for case managers and promotes collaboration across disciplines and programs. VA case managers have access to subject matter experts and extra support when needed to address Veteran case management challenges.

Value to the Community

VA case managers have partnerships with case managers in the community, which facilitates proactive unified care plans to help each Veteran appropriately use health care services between the VA and the community.

The VA experiences decreases in employee turnover and sick calls when case managers feel valued and see positive results on Veteran health care goals.

Metrics Representing Value:
As described above, the VA uses risk stratification to identify Veterans with moderate to complex medical and/or behavioral health needs. Once identified, these Veterans are assigned a lead case manager. After a lead case manager is assigned, evaluation of case management activities occurs through the following metrics:

- **Number of emergency room visits at VA hospitals**: Review of Veterans with more than 4 VA emergency room visits within a 12-month period of time.
- **Number of emergency room visits at community hospitals**: Review of Veterans with more than 4 community emergency room visits within a 12-month period of time.
- **Number of hospital admissions at VA hospitals**: Review of Veterans with more than 4 VA hospitalizations within a 12-month period of time.
- **Number of hospital admissions at community hospitals**: Review of Veterans with more than 4 community hospitalizations within a 12-month period of time.
- **Number of readmissions within 30 days**: Review of Veterans with more than 4 readmissions within a 12-month period of time.

The VA has identified that Veterans demonstrate more appropriate utilization of healthcare resources when assigned to a dedicated lead case manager. Lead case managers provide proactive, personalized, and Veteran-centered services to help Veterans navigate intimidating healthcare systems and processes. VA case managers advocate for Veterans and help streamline services to reduce barriers and challenges and improve the Veteran experience.

Long-Term Care and Assisted Living

Shawna G. Kates, MSW, MBA, CMAC

Case management is a driving force in directing patients toward services to achieve optimal health at their targeted level of care. The role of a professional healthcare case manager may be more episodic in some settings (e.g.,: hospital), or longer-term in other settings (e.g., primary care). Whether called "care coordinator," " care manager," "social service coordinator," or "case manager," their evidence-based case management functions are carried out in all settings and are the underpinning of this highly specialized discipline. Regardless of the setting or duration, Case management offers a system of care guided by a strategic roadmap, providing direct intervention to address the needs of high-risk and high-cost populations. Case management roles that have limited scope and impact on the longitudinal plan of a patient rely on the partnership of the patient's "collective team" through "handovers" or transition planning efforts. Facilitating smooth transitions from one health setting to another is a key function of healthcare community case managers, who use their skills to translate the current patient/provider's plan to the next location and set of providers,

Roles and Responsibilities

Case management plays a key role in the community setting (e.g., residential Assisted Living, or clinical Skilled/Long-term care). In these settings, a case manager attends to vital transactional services as well as planful coordination and implementation of care for patients who are arriving to the community setting, establishing care there, or transitioning from the community out to another setting. The essential tasks of the case manager in Assisted Living or Long-term care that benefit the patient, the team, and the organization include:

- The professional case manager completes an initial comprehensive assessment, and then reassesses at a frequency prescribed by the state regulations and program structure. In the advocate role, the case manager can utilize the results of their comprehensive assessment to be the "voice" of the patient's overall care plan, assuring the care plan addresses developmental, cognitive, ethical, and ethnic diversity needs.

- Whether a health care case manager is focused on episodic intervention or engaged in intra-setting or cross-setting transitions to higher or lower levels of care, or management of a patient in the community, the value of case management to the patient, organization, peer, and community is demonstrated through three values--clinical, psychosocial and financial.

- While all three themes are interrelated, clinical value may be demonstrated through the achievement of outcomes such as stable disease management, reduced hospital admissions, decreased mortality and morbidity, decreased use of prescription medication, and compliance with scheduled medical management appointments.

Value to the Patient/Family

The case manager targets transition planning to increase sustainability in the community by ensuring each patient is placed into the level of care which provides all needed services with the least restrictive environment possible. A well-coordinated transition plan will; reduce risk and cost, and achieve the transition in an efficient and timely manner. The case manager is instrumental in coordinating resources to meet the patient's social determinants of health needs before, during, and after the transition in or out of community care.

Value to the Organization

Case management's value to the organization can be seen in the coordination of follow-up plans after hospital discharge to a community care setting. For example, they can assist with ensuring timely outpatient follow-up appointments occur with MDs, thereby reducing readmissions and positively impacting the Medicare quality metrics. From a financial perspective, the case manager collaborates with value-based model contacts, accountable care programs, and payer post-acute contact person to support the patient and the financial goals of the bundled plans.

Financial return on investment that denotes the value of case management services may include shorter length of stay in a rehabilitation site prior to discharge home, reduction in pharmacy costs, increased enrollment in chronic care case management programs, and successfully meeting the benchmarks set by pay for performance programs.

Value to Colleagues

The case manager supports their colleagues as a central member of the healthcare team through communication, documentation, referral, and implementation of services (when appropriate) that help address acute or chronic patient needs.

Value to the Community

Addressing Social Determinants of Health

Psychosocial benefits of a sound case management program may include the patient/caregiver's ability to develop a life-affirming care plan, demonstrate self-management skills, complete Advanced Directives and Physician Ordering Life-Sustaining Treatment (POLST), achieve lower scores on Social Determinants of Health screening tools, manage unique needs related to diversity, improved Quality of Life survey scores, and participate in patient education activities.

There has been an ongoing debate regarding which professional discipline (nurse versus social worker) is more appropriate to support linking patients with needed clinical services to achieve safe transitions, and/or achieving sustained wellness in the community, and/or ensuring the patient's emotional wellbeing/self-activation. Both disciplinary backgrounds bring value, underscored by training, skill development, competence, and principled practice.

Metrics Representing Value:

Case managers may achieve tangible results (e.g., ordering durable medical equipment to support patient autonomy), or steer toward higher level, strategic goals (e.g., reduced frequency of hospital readmissions through disease management services), or establish soft goals (e.g., assisting a patient/family on collective decisions about end of life care).

When discussing case management in a community setting, such as Assisted Living or Long-Term Care, the determination of which discipline becomes the case manager is often guided by State or Federal Regulations. The Office of the Inspector General denotes requirement for "social services" for long-term care, which regulates staffing of a full social worker only for facilities greater than 120 beds (*Psychosocial Services in Skilled Nursing Facilities*, 2003).

Physician Advisor

Thomas Higgins, MD, MBA, FACP, MCCM

"Ninety-nine percent of who you are is invisible and untouchable."
- R. Buckminster Fuller

The world celebrates and rewards elite athletes, pop musicians and billionaire businessmen. In the world of medicine, the spotlight typically falls on the innovative surgeon, the charismatic CEO, or the media-savvy researcher presenting controversial data. But ninety-nine percent of us simply and quietly keep patients healthy, arrange their medical interventions, and facilitate the smooth functioning of a complex health system. There is rarely recognition for keeping the trains running on time, though fingers will rapidly point if there's any delay.

Physician Advisors, along with their colleagues in case management, will derive personal job satisfaction when patients improve. Our invisible actions facilitate safe and effective transitions in care, promote healthy patient recovery, and keep costs under control through efficient deployment of resources. But, there is a danger, particularly at budget time, that the value of our work becomes invisible, and potentially considered expendable. Knowing and promoting our value is thus an existential imperative!

Value can be defined as "the importance or worth of something for someone." In health care, the "something" can be clinical recovery, patient and family satisfaction, or a positive bottom line financially. The first focal point for who we strive to deliver value to should be the patient, but families, co-workers, management, and payers are all stakeholders who seek value as well. In the past, the typical physician advisor was primarily responsible for meeting the requirements of utilization review mandates and was often a late-career physician with longstanding collegial relationships with the medical staff. They had a minor impact on value in the era before Medicare (and some other health insurance companies) instituted the Diagnostic Related Group (DRG) to determine reimbursement for each hospital stay. The Physician Advisor job descriptions began to change in the mid-1990s, but more remarkably following the enactment of the Affordable Care Act (ACA). A hospital's upper management, including the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO), may not be familiar with these changes, and balk at providing necessary resources for an effective Physician Advisor program.

A highly functional program addresses proper status determination (admission versus observation), a prospective plan for safe discharge, dealing with prior authorizations, patient flow management, addressing appeals and denials, and continuing education of everyone on the team. Hospital and system finance personnel are now stakeholders in a way that was formerly inconceivable in the "cost-plus" era of healthcare financing.

Putting a dollar figure on Physician Advisor tasks is difficult but possible. One study promoting high-value inpatient care via a coaching model of structured interdisciplinary team rounds documented a reduction in geometric mean length of stay (GMLOS) from 4.71 to 4.23 days on a medical ward, as well as a 0.3 day reduction in the top 11 DRG's that accounted for more than half of patient volume (Artenstein, et al., 2015). Prospectively setting a designated discharge time decreased the average length of stay (LOS) from 47 to 43 hours and increased the number of morning (before noon) discharges by 30% (Sklansky et al., 2019).

While the cost benefits of shaving a few hours off one patient's LOS may be imperceptible, it adds up rapidly when applied to all inpatients over a fiscal year, often with unmeasured secondary effects such as reducing "left without being seen" rates in the Emergency Department (ED). Deploying hospitalists in the ED can reduce observation time from 29.7 to 26.0 hours, saving $1072 per patient, or a total estimated direct cost savings of $187,660 for 175 observation patients over a three-month period (Hrycko et al., 2019).

Value to the Patient/Family

Today's patients are increasingly complex with escalating needs, not only from clinical co-morbidities but also social determinants of health. Patient care management has become a team sport with many specialty position players – not only the attending physician, consultants, and bedside nurses, but also family members, pharmacists, purveyors of durable medical equipment, home health agencies, and long-term subacute facilities. Everyone needs to understand what the others require for success. Retrospective utilization review is necessary but no longer sufficient.

Value to the Organization

Contemporary roles for the Physician Advisor in case management include providing input to daily case management processes (e.g., status determinations, condition code 44 adjustments), interacting with insurance companies and Recovery Audit Contractors, conducting complex care rounds, managing patient flow both routinely and in a "code help" bed crunch, and facilitating discharges during times of high census. Ideally, job functions include continuing education of the medical staff on regulatory requirements, how to determine patient admission status, clinical documentation improvements, and techniques to reduce avoidable days. It helps if the physician advisor is a "player-coach" who fully understands the time constraints of a typical hospitalist or primary care provider.

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Value to Colleagues

Physician Advisors also raise value by deepening their partnerships with the case managers. The physician's clinical perspective informs discharge planning (thus decreasing avoidable delays to discharge), and expectations when an individual patient's expected arc of care will differ from the DRG-predicted GMLOS. That trajectory of care can also be nudged in the right direction through interactions with the attending physician not only for inpatient scheduling (e.g., anticipating imaging or other needs) but also knowing what can be reasonably and safely accomplished post-discharge. The wise Physician Advisor keeps track of the effect of these interventions, and can then partner with the CFO to quantify this value in dollar terms.

Metrics Representing Value

The value proposition is ultimately quality of care indexed by cost, but more specifically by metrics including:

- Clinical outcomes
- Proper patient placement
- Length of stay, readmissions
- Effective post-acute care
- Reduced denials

Social Work in an Inpatient Setting

Marisa Glover, LMSW, MHA

In the dynamic landscape of healthcare, the role of a Medical Social Worker within an inpatient setting holds immense significance. Their responsibilities encompass case management, utilization review, quality assurance, and discharge planning, all of which contribute to the holistic care of patients. Social workers play a critical role in healthcare settings, particularly in inpatient environments where patients often face complex psychosocial challenges alongside their medical conditions. The presence of a medical social worker in such a setting significantly enhances patient care, provides valuable support to families, and contributes to the overall functioning of the healthcare organization.

Roles and Responsibilities

The Medical Social Worker undertakes a comprehensive range of responsibilities, starting with case management. This involves assessing patients' psychosocial needs, identifying specific requirements, and intervening with appropriate social services during their acute stay. These professionals are also entrusted with utilization review tasks, including admission, concurrent, and retroactive reviews. Ensuring compliance with regulatory requirements such as Medicare and Medicaid are central to their role. Furthermore, they engage in quality assurance activities, surveilling data for trends, and formulating action plans to enhance patient care.

Value to the Patient/Family

At the heart of the social worker's role is the benefit they offer to patients and families. Their assessment skills are pivotal in identifying patients' psychosocial needs and determining appropriate interventions. Their expertise in assessing the human psyche allows them to provide insightful observations and recommendations. By fostering an environment of open communication, social workers empower patients and families to make informed decisions about their healthcare journey. They offer emotional support, coping strategies, and resources to navigate the challenges that often accompany a hospital stay. This psychosocial value extends beyond medical treatment, contributing to the overall well-being of patients and families.

By fostering an environment of open communication, social workers empower patients and families to make informed decisions about their healthcare journey. They offer emotional support, coping strategies, and resources to navigate the challenges that often accompany a hospital stay.

Value to the Organization

Social workers contribute to the financial and operational well-being of healthcare organizations. From a financial standpoint, the value of social workers is twofold. Firstly, they play a pivotal role in ensuring that patients receive the appropriate level of care. By conducting utilization reviews, they prevent overutilization of services, thereby optimizing resource allocation and reducing unnecessary costs. Secondly, their involvement in quality assurance efforts leads to improved patient outcomes, reduced readmission rates, and enhanced overall patient satisfaction. By streamlining the care process and minimizing inefficiencies, social workers contribute to the organization's financial stability. Furthermore, their involvement in quality assurance activities helps identify trends, enabling the organization to implement effective interventions and improve care delivery processes. Social workers are integral team members, collaborating with medical staff, which enhances interdisciplinary communication and the overall efficiency of the organization.

Value to Colleagues

IIn the collaborative healthcare setting, social workers' value extends to their colleagues, both internal and external. Social workers are trained to work effectively within multidisciplinary teams, fostering a culture of teamwork and adaptability. Their resilience in the face of change sets an example for their peers, emphasizing that adaptability is essential in an ever-evolving healthcare environment. Their expertise in addressing psychosocial aspects complements the clinical expertise of other healthcare professionals, resulting in more comprehensive and patient-centered care. Their willingness to embrace change and contribute to innovative solutions fosters a positive work environment. Social workers offer insights from a psychosocial perspective that enriches discussions among medical professionals, ultimately leading to comprehensive patient care.

Value to the Community

(***Addressing Social Determinants of Health)***

Social workers stand as advocates for the community, particularly in addressing the social determinants of health (SDoH). The World Health Organization defines SDoH as non-medical factors that influence health outcomes, such as economic policies, social norms, and political systems. Social workers, equipped with a deep understanding of these determinants, are uniquely positioned to address health inequities and advocate for change. By working on the frontline to tackle issues like homelessness, poverty, and access to education, they contribute to healthier communities and promote equity in health outcomes.

Metrics Representing Value:
Quantifying the value of a social worker's role can be challenging due to its multifaceted nature. However, several metrics can provide insight into their impact. These include:

- **Patient Satisfaction Scores**: High patient satisfaction scores reflect the positive influence of social workers in addressing psychosocial needs, fostering a sense of comfort and support.

- **Readmission Rates**: A lower rate of patient readmissions indicates successful discharge planning and psychosocial support, leading to improved outcomes.

- **Resource Utilization**: Tracking resource utilization before and after the involvement of social workers can highlight their effectiveness in optimizing resource allocation.

- **Health Equity Measures**: By tracking the progress made in addressing social determinants of health, such as reduced rates of homelessness or improved access to education, the impact of social workers on community health can be gauged.

In conclusion, the value of a Medical Social Worker in an inpatient setting is extensive and multifaceted. Their contributions extend beyond clinical care, encompassing psychosocial support, cost optimization, interdisciplinary collaboration, and advocacy for healthier communities. The metrics mentioned above provide glimpses into their impact, yet the holistic nature of their role defies easy quantification, as it resonates deeply with the well-being of patients, families, organizations, colleagues, and the broader community.

OUTPATIENT GUIDES

Care Continuum

Bonnie Geld, MSW

Knowing the value of the various sites of outpatient care ensures a more comprehensive approach to health care in our neighborhoods, our communities, and the nation. This section of the paper will walk you through the various outpatient settings and value statements for each site of care.

Through an array of discreet functions, case management services brings clinical, psychosocial, financial and other goals together at both the organizational and patient care level. The value of case management in supporting patients through the care continuum is significant as this profession can be the "make it or break it" factor for the patient.

Today's extraordinarily complex system of primary care providers, specialists, diagnostic centers, and emergency and urgent care centers has created confusion and frustration, with challenges to access, continuity, and reliability of care. Unfortunately, today's healthcare system does not ensure equal access for all. Even amongst insured patients, not all individuals are eligible for the same services. Case management is focused on organizing, coordinating, and helping patients successfully navigate these systems toward better and more proactive management of their healthcare.

The ambulatory care settings represent the largest aspect of a patient's health care journey. Properly managed outpatient care can help avoid or reduce the need for costly inpatient care. The value provided by case managers and social workers is demonstrated in partnerships, in advocacy, and in actions to empower patients and their families to feel in control of their health and their care plan

What is the magic performed by case managers and social workers? Trained and licensed RNs and social workers position themselves to support clinical, psychosocial, and financial outcomes.

Clinical Outcomes:

Case managers in outpatient settings support patients (and their families) with managing chronic disease, terminal illness, and acute care recovery. They do this by supporting, teaching, and empowering their clients. Case managers range from specialists in specific disease states (e.g., congestive heart failure, diabetes), to chronic illnesses in general, or recovery from an acute health event. Working one-on-one with patients and their families, they help ensure health literacy is addressed and the patient is supported during their multifaceted health care journey.

Psychosocial Outcomes:
RN Case Managers partner with Clinical Social Workers and Community Health Workers to address two aspects of need:

- **Social Determinants of Health**: Ensuring patients and families know the community resources available to aid in their health care recovery and what they are eligible for while assisting/advocating for them in gaining access.

- **Mental Health Support for Emotional Wellness, Adjustment to Illness, Depression, etc.**: Clinical Social Workers are great partners and can provide some level of clinical interventions. They often make the difference in ensuring patients understand their illness and have the emotional tools to cope with recovery or management of their disease.

Financial:
Navigating the healthcare system alone is overwhelming. In and of itself, the financial burden can be catastrophic to the personal resources of some patients and families, even when insurance benefits are in place. Case managers and social workers often navigate these systems for patients and families in the following manner:

- **Health Care Benefits**: Access to the health care a patient needs which includes primary and specialty care. Examples of this include:

    1) Access to Federally Qualified or Charity Health Care Clinics
    2) Advocating for specialty care through their Health Care payer or provider
    3) Ensuring a benefit is authorized (i.e. medications, DME)

- **Personal Resources**: Access to resources that support patients' ability to manage illness in their community and institutional resources. Examples of these include:

    1) Pharmaceutical Assistance Programs
    2) Disease Specific Organizations (National Kidney Fund, American Cancer Association, etc.)
    3) Social Service Agencies (Meals on Wheels, WIC, etc.)
    4) Community Agencies (Senior Service Organizations, Area Agency on Aging, Healthy Start, etc

The value of case management is all-inclusive. When positioned correctly in each setting, skilled management will provide the support patients need, keeping it in balance with the financial stability of the healthcare organization.

Value to the Patient/Family

The impact of case management is substantial and offers patients and families a roadmap towards better management of their complex healthcare journey. Case management professionals work in the service of the patient and family, but also within the reality of reimbursement, with an awareness of the need for efficiency. Nurses, professionals, social workers, physicians, and others working in case management provide the engine that drives coordinated care as each patient and family receives a customized pathway through their healthcare journey.

Value to Colleagues

Case managers and social workers are critical members of the interdisciplinary teams. As experts in active listening and empathy, they can lead crucial conversations with accuracy and share their expertise and approach with other healthcare team members. Their collaborative work results in improved communication and strengthened relationships.

Value to the Organization

Supporting patients and families will ultimately improve access for all patients and support and ensure appropriateness of reimbursement. ACO and integrated care organizations will realize the benefit of reducing the incidence of hospitalizations and unnecessary emergency department care.

Value to the Community

Awareness of and confidence in this profession ensures that patients and families will embrace the support that case managers provide, enabling patients to achieve better health and lead more productive lives as members of their community. The community, at large, will have better access to care when needed, as case management can enable easier engagement with primary and secondary providers, improving utilization of routine care services, and reducing emergency department wait times.

Metrics & Outcomes:
Data clearly supports the value of outpatient case managers/social workers. There are "soft" data outcomes such as patient/family satisfaction and patient engagement, as well as quantitative improvements in critical outcomes that are considered the "vital signs" of healthcare organizations.

- **Improved financial performance**: This discipline is positioned to both maximize revenue and decrease costs and penalties.

- **Reduction in unnecessary emergency department visits and hospital admissions:** Ambulatory Case Management and social work teams add value in both the inpatient and ambulatory settings. For instance, strong Disease Management and Chronic Care programs in ambulatory clinics will reduce unnecessary emergency department and admissions.

Knowing the value of the various sites of outpatient care ensures a more comprehensive approach to health care in our neighborhoods, our communities, and the nation. This section of the paper will walk you through the various settings and value statements for each site of care.

Care Transformation Coach in Value-Based Program

Lisa Parker-Williams, DNP, MBA, RN, CCM

Primary care practice has had to redevelop itself over the last twenty years. The Affordable Care Act began the healthcare transformation in the United States (Peikes, et al., 2020). In 2011, Horizon BCBSNJ, the New Jersey Academy of Family Physicians, and leaders of eight primary care practices, launched Horizon BCBSNJ's Primary Care Medical Home (PCMH) Program as an initiative to help meet healthcare changes and address the tenets of the Quadruple Aim. The goal of the PCMH is to provide a registered nurse to serve as a population care coordinator who assists primary care practice teams in providing patients with care where and when they need it (Primary Care Collaborative, 2015). The author of this section is one of the original population care coordinators who received a Population Care Coordinator Certificate from the venture between Horizon BCBSNJ, Duke University School of Nursing, and Rutgers College of Nursing.

The CMSA Standards of Practice (SOP) shares that advocacy is a driving factor for the case management profession (CMSA, 2022). The role of a Care Transformation Coach involves instructing healthcare leaders in the hospital, accountable care organization, or aggregator setting on the importance of primary care practice transformation to improve the goals of the Quadruple Aim. The SOP defines case managers as "healthcare professionals who serve as patient advocates to support, guide and coordinate care for patients, families, and caregivers as they navigate their health and wellness journeys," (CMSA, 2022).

Case managers stress the importance of patient-centric care while educating healthcare leaders on the importance of providing patients with educational tools and resources to allow them to drive their healthcare decisions optimally. (Hortsman, et al., 2021). According to MasonIn particular, the Care Transformation Coach training program focuses on key skills for coordinating care at a population level. The care transformation coach has also evolved to include licensed clinical social workers because they, like nurses, provide effective and efficient healthcare that aligns with the principles of professional case management.

Value to the Patient/Family

The coach advocates for the patient and family as providers strive to improve their patient experience. The work performed by the coach aligns with the SOP principles of implementing evidence-based care guidelines in the practice setting. This work is also instrumental in educating providers about the "whole" needs of the patient.

Value to Colleagues

Internally the coach possesses the necessary skills to transform analytical data into clinical reasoning, which is crucial in achieving optimal health outcomes. According to the U.S. Department of Health and Human Services, the involvement of primary care practice is crucial in improving population health and reducing health disparities (U.S. Department of Health and Human Services, n.d). A Care Transformation Coach, provides directions to improve outcomes while collaborating with internal and external partners to be an effective patient advocate to improve population health.

Value to the Community

The coach role is valuable to the community because in the process of educating providers on value-based care, we discuss the importance of community outreach and addressing the social determinants of health that impact patient outcomes.

Value to the Organization

The coach role is valuable to the organization because the coaches provide clinical insight on improving patient outcomes through achieving quality outcomes measured by the Healthcare Effectiveness Data and Information Set (HEDIS), reducing emergency department and inpatient utilization, and educating providers with evidence-based tools and techniques to impact the results of value-based programs.

Community-Based Case Management/Disease Management

Jennifer Axelson, LCSW, CCM, CLCP, CMCPS

Community-based Care Managers (CM) fulfill many roles and have a variety of responsibilities for their organizations, clients, and teammates. Case managers are the conduit that connects all aspects of our care and business, including, but not limited to, client care, teammate support/training, administrative support/oversight, and community relationships.

Client Care

Case managers are tasked with providing support and oversight for home care services, while also providing concierge services focused on advocacy, healthcare coordination, and care facilitation. These clinicians conduct assessments or consultations for all prospective clients. Great clinical assessments are fundamental in the identification of patient challenges and the development of a comprehensive care plan. As the patient and/or their family needs change over time, different types of assessment are necessary to ensure an ongoing understanding of the patient's overall needs and ability to manage their health needs in the community.

Assessments

Focused assessment:

- Meet with the client or family for caregiving services
- ADL / IADL assessment
- Determine which tasks a caregiver will perform
- Gather client information (e.g. contacts, medications, etc.) to develop a care plan
- If non-caregiving issues present themselves, the CM will offer to do a consultation for the resolution of problems
- Consultations

More comprehensive assessment:

- Address all of the points listed in the Focused Assessment, and
- Stabilize a crisis or issue
- Educate the client on ALL issues (e.g., Medicare coverage, challenging behavior stabilization, family disagreements)
- Teach the current and ongoing value of care management
- Educate family regarding long-term care plans
- Relieve client anxiety; focus on helping clients achieve their goals involving purpose

From the first day of home care services, case management is front and center to make the official in-person introduction between the client and assigned caregiver. They perform regular check-in phone calls with caregivers, clients, family members, and other involved parties.

The case manager evaluates the patient's progress on a weekly basis and makes updates to the care plan. These include evaluating the patient's needs and increasing the hours of care if indicated, identifying additional training needed for the care team as the client's needs progress, making adjustments to the ADLs/IADLs, and providing care management services.

Standardized, best practices in this role include:

- Complete home care supervisory/wellness visits to monitor for changes in the client's condition
- Accompany the client to doctor's appointments, serving as a client advocate, identifying additional resources, and managing family dynamics
- Find opportunities to provide care management services to improve quality of life for existing clients and their families

Teammate Support/Training

Experienced case managers will provide support to colleagues in various ways. They are best described in the following manner:

- Coach and train caregivers:
  In-home training
  In-home skills assessment and training
- Teammate support

CMs are integral in creating a culture of gratitude through meaningful experiences. Connecting with and enriching this culture can be created through:

- Birthday and anniversary acknowledgments
- Immediate feedback via compliments from clients and office team members
- Handwritten thank you cards
- Weekly text/call/card check-ins with teammates to offer support/appreciation

Administrative Support/Oversight

CMs are responsible for a good deal of the administrative work related to client care, including:

- Service agreements
- Welcome packages, forms, and communication with clients/families/ responsible parties
- Client note, care, and treatment information maintained via systems
- CMs participate in operations and systems work through collaboration with various departments. They are the end user and/or the subject matter expert who can offer insight.

Community Relationships

CMs are integral in building relationships with professionals, prospects, and the community at large. This can be achieved through:

- Presentations (virtual or in-person)
- Scheduled meetings
- Sponsorships/events
- ·Conferences
- Social events with referral sources and/or their clients/residents
- Electronic/web-based outreach (ex: LinkedIn)
- Providing great care to clients
- Reaching out to trusted advisors/contacts for your current clients
- Always presenting yourself as a representative of the company
- Impromptu conversations with referral sources

Case managers and social workers perform critically necessary roles in the community to support each patient's health care journey. Their value is experienced daily.

Value to the Patient/Family

The case manager provides continuity and daily support. Through their ability to provide this oversight, they are able to quickly identify if and when the patient is experiencing unique challenges and work with them to resolve this. One example is by advocating for more resources.

Value to Colleagues

Through mentorship and teamwork, the case managers become their own community and support each other to ensure standardized, best practices in the field.

Value to the Community

Case managers build important relationships in the community which ensures that patients and families will effectively and efficiently be connected to resources they may need. They advocate for this support to ensure connectivity.

Value to the Organization

Case management support to patients and families also supports the organization. By ensuring the patient is receiving what they need, navigating the system, and utilizing community support, case management influences cost and reimbursement.

Hospice and Palliative Care

Melissa Ward, MSN, BSN, RN

Hospice and palliative care case managers adhere to a fundamental principle that guides their work, which is to offer support and care to enhance the quality of life for patients diagnosed with a serious medical illness or life-limiting condition.

In hospice care, the case manager's responsibilities are focused on addressing a patient's physical, emotional, and spiritual needs, and managing pain or other symptoms in the final stages of life. In palliative care, the case manager's role is extended to aiding patients and their families in coordinating treatment-related services and supporting the management of symptoms associated with a serious illness. Case managers can be distinctly allocated to hospice care or palliative care, or they can have a dual role. They are adept at clarifying the distinction between palliative and hospice care and tailoring their communication, language, and approaches to meet the needs of the patient and family.

The case manager's caseload fluctuates based on the needs of their patients. The process of educating and actively involving patients and families in care planning alongside the interdisciplinary team begins at the time of enrollment in hospice or palliative care services, with the initiation of the care plan. The care plan establishes the basis for coordinating the goals of care, as the location, frequency, and level of care may all vary based on identified care needs. During a time of crisis (as frequently occurs to signal the need for hospice or palliative care services), case management offers invaluable support for patients and families. Their collaborative work with other members of the healthcare team results in improved communication, strengthened relationships, and refined approaches.

Hospice and palliative care case managers are experts in leading difficult discussions. Their language and conversations highlight empathy, patience, and a patient-centered approach to help patients and families make informed decisions. Their role in helping initiate care early in the patient's journey through critical illness or end of life care translates to savings for the organization and the patient. Organizations can benefit from hospice and palliative care case management in two additional ways. First, by highlighting the achieved outcomes as an example of the organization's dedication to timely orchestrated patient-centered care. Second, by appreciating that well-coordinated care will cultivate a patient preference for returning to that organization/health system when other health care needs arise.

Value to the Patient/Family

Early proactive conversations and interventions allow patients and families more time to understand the options and make informed decisions that meet their preferences. Navigating the healthcare system when faced with medical complexities can be very challenging for patients and their families. With the case manager serving as a central point of contact, patients benefit from timely care coordination and effective communication which can help prevent unplanned hospitalizations or medical visits, thus creating a more positive experience for patients and families.

Value to Colleagues

Hospice and palliative care case managers bring value to both external partners and internal colleagues. Their knowledge and expertise contribute to staff satisfaction and positive experiences for patients and families. As experts in active listening and empathy, they are able to lead crucial conversations with accuracy and share their expertise and approach with other healthcare team members.

Value to the Community

Case managers can direct individuals to valuable resources within the health care system, the patient's portfolio of insurance benefits, and organizations in the community. Sharing these resources, along with data on outcomes, ensures a better patient experience and builds trust and confidence. Collaboration with community partners can create innovative solutions and continue opportunities to ensure patients will have safe and seamless care coordination that minimizes delays and maximizes positive patient outcomes.

Value to the Organization

The financial impact of care is significant for both healthcare organizations and families. Efficiently coordinated care delivery can help alleviate unnecessary costs and stress, benefiting both the organization and patients. Current fragmented healthcare delivery systems result in delayed access, delayed treatment, and persistent gaps in care. Bridging these gaps is crucial. Comparing the costs of non-orchestrated versus orchestrated care highlights the advantages of a streamlined approach for organizations and families alike.

Independent Practice - Geriatric

Cheryl A. Acres, RN, CCM, CDP

The author of this section is an RN who provides geriatric care management services to individuals and their families, as a solo business owner/entrepreneur.

According to the Aging Life Care Association, "Aging life care, also known as geriatric care management, is a holistic client-centered approach to caring for older adults or others facing ongoing health challenges. Working with families, the expertise of Aging Life Care Professionals provides the answers at a time of uncertainty."

As people develop increasing medical needs throughout the aging process, their families are often sought out to provide help navigating the fragmented healthcare web. As such, aging patients and their families embark on a journey for which they have little to no preparation. At the same time, the elderly family member may be resistant to receiving help, or possibly in denial about their needs. They may push back on the new role reversal of the adult child now having to parent the parent. In other situations, the aging person may not have any remaining family to rely upon, for a variety of reasons. If there are cognitive issues—whether a mild decline or clinically diagnosable dementia, the situation may become even more complex.

Referrals for care management may come from a wide variety of sources:

- Word of mouth,
- Elder law attorneys and probate court judges,
- The Aging Life Care Association,
- Business networking with other providers in the senior services industry,
- Trust officers,
- Employee assistance programs, senior health fairs, speaking presentations and more.

The referrals from legal sources often involve family disagreements about the care needs of the elder. In some cases, there may have been financial exploitation or some other type of abuse. In other cases, an elder with dementia and no power of attorney in place could be facing a guardianship process.

After a referral is received, the geriatric care management process begins by performing a brief phone consultation with the referral source or the family member. After phone consultation, a home visit is planned (wherever "home" is) in order to assess the status of the client. Assessment includes gathering information on the medical, social, psychological history, and possibly performing a cognitive evaluation. All current services that may be in place are also reviewed, including those provided by family, private caregivers, or insurance-reimbursed care. The process is described in more detail below.

Home Evaluations

If the evaluation is being done in the home, a full environmental evaluation is also done to assess for the following risk factors:

- potential fall hazards,
- smoke and carbon monoxide detectors,
- bathroom safety equipment,
- any egress issues, including medical equipment obstructing pathways or burglar alarms preventing entry/exit.

The other aspects of the home assessment are:

- **Health literacy:** Gauge the patient's level of understanding of their health conditions and treatments. Provide education on a multitude of issues including disease processes, medication management, health insurance, and other topics individualized for each client.

- A full **medication review** is also done so that a complete and accurate medication list can be compiled and provided with the full written report addressing the findings, providing community resources along with recommendations for short as well as long-term care needs.

- If the elder is in the process of **guardianship proceedings**, testimony from the care manager may be required in court as the subject matter expert, along with submission of the full written report.

Should ongoing care management services be requested by the individual or family member(s) following the initial evaluation, a collaborative approach is taken to specifically address what assistance they are looking for. Some options include attending physician appointments with the patient, reporting back to approved contacts, or providing medication management services (licensed nurses only). In some situations when the elderly patient's health condition of living situation is evolving, the care manager may need to return periodically for ongoing monitoring and evaluation, assessing for additional needs, which may include changing which services they receive or establishing higher levels of those services.

The case management process and standards of practice (CMSA) are always at the forefront, as well as the role of advocate for the senior.

Value to the Patient/Family

Case managers fill a key role by providing peace of mind to the family through emotional support, facilitating communication with providers, and allowing the family to revert to being the family instead of serving as the care coordinators. The value of a case manager may be even higher when the family is located far away with limited opportunities for involvement in-person.

Value to Colleagues

Geriatric care management thrives in a collaborative environment. Because of the wide variety of backgrounds/credentials/training of care managers, clinicians may assist social workers with some of the medical/health issues, while social workers may be able to suggest different community resources. For example, in the Dallas-Fort Worth area, the care managers meet monthly to share information, resources, and ideas—occasionally reviewing case studies for problem-solving. If there are health fairs, sponsorship costs for an exhibit table and advertising may be shared with the members of the unit.

Value to the Community

Care managers may provide education regarding health, the role of the care manager, and community options for care by way of attending health fairs or public speaking on specific topics. Additional education on the role of the care manager may be provided to various physician offices during client-related interactions, as well as monitoring and reinforcing adherence to the client's treatment plan. The care manager may report back to physicians regarding changes in the patient's condition, sharing information from other physicians' appointments, and acting as a resource to coordinate client needs. As the care manager is an integral part of the care team, there may be opportunities to increase communication between the physicians and other providers, including home health care, non-medical home care/caregivers, and hospice.

Value to the Organization

Geriatric care management is generally non-regulated, private practice industry. Value within the private practice organization is measured by metrics specific to each practice. Value to the external organizations we interact with (including physicians, attorneys, clients, and families) is measured in various ways. The positive boosts from receiving thank you cards, verbal feedback, as well as heartfelt hugs are immeasurable. In an absolutely priceless example, one Thanksgiving an elderly client's family member said, "We gave thanks for you."

Managed Care Organizations

Kathy Parry, BSN, RN, CCM

A managed care organization (MCO) is intended to provide health insurance and reduce the cost of providing health care to patients insured by the MCO, while maintaining high quality of care. Case management is practiced throughout managed care organizations. The author of this section is affiliated with Kaiser Permanente of Washington (KPWA), an integrated healthcare system providing both healthcare delivery and insurance to its members.

Case management occurs in specialty areas where the case managers focus on population health for patients with specific disease states such as heart failure or diabetes. Case managers within an MCO perform their role under the direction of medical specialists. They engage with patients to assist with managing their disease process by providing education, medication management, and goal setting in an effort to maintain optimal health outcomes.

At a broader level, Case Management Programs function across the MCO health plan and the care delivery system. Programs include complex case management, chronic condition case management, transition case management, inpatient case management, and post-hospital follow-up for care transitions. Each of these programs is described in more detail below.

Complex Case Management

Complex case management is a 90- to 180-day program focusing on disease-specific education and self-management techniques to support ongoing disease self-management. The program focuses on the following chronic conditions as these have the greatest potential for long-term care needs and improved utilization of health care dollars: diabetes, heart disease including coronary artery disease, heart failure and hypertension, high-risk pediatrics, and respiratory conditions (including asthma and COPD). Patients with high utilization, high-cost, and/or multiple co-morbid conditions are managed in this referral-based program as well. Referrals can be initiated from the primary care provider or specialty care provider at the time of discharge by the inpatient case manager, or by self-referral. The case managers complete an in-depth assessment with the member and develop a care plan with the member to assist with their health care goals, aiming to optimize the patient's self-management of their disease.

Chronic Care Management Program

The chronic condition case management program (otherwise known as CCCM) manages patients in a similar manner to the complex case management program. This program focuses on specific specialty areas that have been shown to negatively impact a member's health—often resulting in the patient/family feeling overwhelmed or unsure of what to do or how to manage their illness. The CCCM program works in tandem with medical specialty teams to focus on disease-specific education, coordination of medical services and coordination of community resources providing the patient with a clear pathway forward. The specialties that are currently managed are cardiology, neurology, and nephrology. These specialty groups were identified as having the highest cost and increased utilization. The members selected for case management have been identified through claims to the CMO insurance over a rolling 12-month period.

Transitions in Care Program

The transition case management program focuses on the 30-day period after an acute medical event, facilitating the successful transition to home, with decreased hospital readmissions. As an integrated healthcare system, the transitional case management program is well-positioned to seamlessly coordinate the movement from an acute-care setting (e.g., hospital) to a community-based setting (e.g., assisted living facility, skilled nursing facility, rehabilitation center). Transitional case management is integral to coordination for members who are receiving care outside the KPWA system. This coordination can be related to the repatriation of the member back to KPWA-networked providers, or assistance with coordinating services between KPWA and external providers.

The final program in case management at KPWA is the post-hospital follow-up phone call or transition call, in which nurses contact members of the MCO within 48-72 hours after discharge from the acute care setting. The nurse completes a brief assessment following their transition home and identifies additional care needs/interventions that may require more in-depth case management. These calls are part of KPWA's program to reduce hospital readmissions. Similarly, Medicare members receive a call from a case management nurse to perform medication reconciliation post-hospitalization as part of the Medicare 5-star program, to conform to HEDIS measures. Completion of a medication reconciliation has been shown to reduce readmission.

Value to the Patient/Family

Patients who receive assistance from a case manager are more engaged in their healthcare and have a better understanding of their disease process. They have an understanding of how to navigate the healthcare system and have increased confidence.

Value to Colleagues

Including a case manager on the health care team improves patient outcomes by promoting health strategies. Better outcomes lead to increased job satisfaction amongst the members of the health care team by increasing their sense of actually helping MCO plan members.

Value to the Community

Patients with well-coordinated care will verbalize their satisfaction with their care to other members of their community, thereby promoting the health plan.

Value to the Organization

Employing a case manager to engage with patients who have high-risk or high-utilization will help decrease utilization, reduce disease-related complications, and decrease or prevent hospitalizations, thereby reducing costs to the organization.

Outpatient/Clinic

Corinne P. Leslie, RN, BSN, CCM

An Independent Provider Association (IPA) is a business entity that allows individual physicians or small group private practices to act as a larger unified group for the purpose of reducing overhead and engaging with insurance providers, while still retaining independent practices. The author of this section is an RN leading a team responsible for carrying out case management activities for IPA members referred to the case management program across all levels of care, with a focus on reducing readmissions, ensuring appropriate ED utilization, and providing patients with education on their healthcare, including their insurance benefits.

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication and resource management; and promotes quality and cost-effective interventions and outcomes. Case management activities are based on nationally recognized case management standards, concepts, and principles.

All case management contacts on behalf of the IPA are telephonic with an option for on-site case conferences as needed. Case managers in this role are acutely aware of the financial costs of health care to society and work toward finding the best solutions for patients while being good stewards of limited resources. During phone contacts and case conferences, the case manager looks for opportunities to meet the needs of the patient on an outpatient basis through a combination of health care services, community services, and social support. One example, not often realized, is identifying a person within a patient's social circle to provide care in various ways such as shopping, transporting, medication management, limited wound care, injections, etc.

Key Roles:

- Administrative Support: A case management company serving an IPA can provide administrative support for physicians who want to remain independent in their practices versus being an employee of a hospital system. Built into this business model are case management services. We manage members (patients) across the continuum of care which can include assistance with overcoming barriers to care, or support with transitions (e.g., after hospital discharge, transitioning in or out of a community care setting, or navigating care during the pre-surgical or post-surgical period).

- Case managers serving an IPA are delegated by health plans to manage their benefits. As a natural extension of that role, the goals of our work include implementing strategies to provide quality care in a timely and efficient manner, while improving preventive care and patients' self-management of care in order to avoid costly medical complications and hospitalizations.

Case managers face the daily realities of members who cannot or will not follow the recommendations of the care plans developed for them. The reasons for poor adherence can range from the belief in free will to the barriers posed by social determinants of health. Case managers are continually looking for creative solutions, partnering with the patient/member as well as other providers—physicians, community social workers, family members—to better engage the patient in their care.

Value to the Patient/Family

Case managers connect patients and families to valuable resources available formally or informally in the community. These resources are a vital adjunct to the professional support which case management consistently advocates for. By making these connections, case managers help ensure that patients and families are surrounded by a full circle of help and caring.

Value to Colleagues

Case management has evolved as a sub-discipline within nursing over the past several decades. As such, many case managers have experience in various settings, including hospital, outpatient clinics, home care, hospice, and palliative care. Each setting leads to collaborative interdisciplinary work with colleagues in other professional specialties.

On a personal note from the section author: “My 40-plus years in nursing have afforded me to join case management as it evolved as a subset of nursing. There is a collaborative spirit in case management which is valued by all partners and helps us to better manage our members. We can’t do this alone.”

Value to the Community

Utilizing care managers to be good stewards of care and cost results in a healthier population with decreased hospitalizations and more appropriate use of emergency departments.
Case managers support communities in need, either short- or long-term (episodic or chronic disease management). Case managers make an impact on patients, families, schools, churches and more by the work they do.

Value to the Organization

Case managers achieve improvements in health care spending on behalf of the organization.

As depicted in the descriptions of these settings, RN and Social Work Case Managers maintain their value as clinicians, colleagues, employees and members of the community at large. The CMSA standards of practice are held as the North Star of their practice and are meant to demonstrate the value of our discipline and our profession.

Worker's Compensation

Thomas F. Fisher, PhD, OTR/L, CCM

Care management has emerged as a primary means of managing the health of a defined population. Its purpose is to reduce health risks and the cost of care for a defined population. For this proposal, the population is injured team members in an employment setting. To enhance care management, one must identify the population with modified risks, align care management services to the needs of the population, then identify, prepare, and integrate appropriate personnel to deliver the needed services. (AHRQ, 2017)

In the US, case management historically originated as an aid for people seeking worker's compensation within the railroad industry after accidental injuries on the job, in an effort to controlthe spiraling costs of health care while still ensuring adequate treatment. Initially, the process of case management only involved utilization review (UR). UR embraced the constellation of services aimed at ensuring injured employees received medically necessary care, delivered in the most cost-effective setting and manner, while maintaining quality of care. If the quality of care for clients is compromised to save money, the patient (injured worker) is not only at risk of complications, but the insurer is at risk for increased costs if the condition worsens because of inadequate or inappropriate care treatment.

As with all areas of case management, many of the roles and responsibilities remain constant:

- Coordination of care and services
- Facilitation of the client's timely access to services
- Engaging the client and family in decision about care options
- Monitoring client's condition and adherence to plan of care
- Facilitating team meetings (physician(s), OT, PT, others as appropriate) with the client
- Coordination transition of care – work conditioning, work hardening, services onsite
- Assuring the client keeps appointments and brings appropriate information with them

In addition to these, with an injured and/or ill worker (worker's compensation) population, additional responsibilities for an external case manager include:

- Keeping the employer apprised of the injured worker's progress. This may be the worker's supervisor, the employee health nurse or company physician (if there is one), the internal case manager (if there is one), Human Resources manager, or the Risk Management Department.
- If there is a Third-Party Administrator (TPA), the case manager also needs to keep them informed of progress.
- Employee Assistance Programs (EAP) may be involved and would also need to be kept apprised of progress by the case manager.
- At times, the employee (injured worker) may be in a labor union employment situation. If so, the case manager would need to determine who the union representative is, and what is and is not allowable for discussion. HIPAA must be respected and followed by the case manager.

- Attorneys may also be involved, and the case manager must be attentive to which information can or cannot be shared.
- The case manager will attend medical visits with the employee/injured worker if the worker desires to have them there to hear options and to help interpret medical and therapy records.

§ (Tahan & Treiger, 2017)

Case closure is the goal, regardless of whether the final outcome involves returning to work at full duty, reduced/modified duty, or not. Sometimes the worker might achieve Maximum Medical Improvement but cannot return to work. When that occurs, a physician makes a disability determination which leads to the employee receiving a payout for their injury and/or illness. This is an obligation the employer will need to meet. Having a case manager to help the injured employee navigate this process is invaluable. Most individuals do not know the questions to ask nor the options available.

Value to the Patient/Family

Ensure that the worker is receiving compensation while off work. Help coordinate all medical, rehabilitation, and (occasional) vocational services needed to address the injury/illness to achieve Maximal Medical Improvement, and potentially enable the worker to return back to the same job or different job with the employer.

Value to Colleagues

Navigating the case together with other CM colleagues in other settings ensures alignment and consistent support to the patient/family.

Value to the Community

Supporting these patients allows them to return to their workforce, offering the community a more productive population.

Value to the Organization

Value and protection are provided to the organization. Streamlining employee health and rehabilitation care internally is cost-effective and value-added for the employer. Essentially, supporting the patient's return to work is highly efficient for the organization.

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