

Introduction: Biography of a Case Manager

Case management is not for the faint of heart. It is not for those seeking to avoid the stress of a hospital setting or the stretch of working with patients and families in distress. Providing intervention on behalf of the patient, medical provider, and payer (insurer), a case manager must place him- or herself at the center of the confusion in today's healthcare delivery system and be willing and able to ask the tough questions. Is that surgical procedure appropriate and necessary? Can we do better on pricing for total parenteral nutrition (TPN) infusions or the out-of-network rehabilitation programs? Can we honor patients' wishes and enable them to live their last days at home? And because case management is a process, a case manager must commit to go the distance, offer ongoing, on-site, individualized services, and become involved in finding medical treatment alternatives, monitoring results, solving problems, and revising the treatment plan as needed. A case manager is the catalyst who sifts through the array of possible paths, selects the most appropriate plan, and then coordinates the expertise and support of other professionals, family members, agencies, and suppliers. Case managers are concerned with every detail, from the minute—is the noise from the oxygen concentrator disruptive, preventing the patient from utilizing it?—to the major—can the family member, home health aide, or RN in attendance handle a patient emergency? Is the family rejecting the needed hospital bed because they don't want their den to have a sick room look?

The role of the case manager is an amazing combination of perception, planning, listening, empathy, and caring to support the professional case manager in relating to and engaging with patients in their care. Part I takes a look at the complete profile—the biography of the case manager.

The Case Manager as Catalyst, Problem Solver, Educator

Case management is everything you hoped it could be, and it as special as the caring hearts of the professionals who will embrace it. It is not an easy professional specialty, but it is a tremendously rewarding one. As a discipline, case management requires an understanding of how various medical, insurance, government, and corporate mechanisms affect the healthcare delivery system. Each of these areas influences the type of care available and how it will be administered. It is the case manager's responsibility to know the distinctions among acute hospitalization, subacute care, and specialized chronic care; the results and impact of federal legislation; and the coverage offered by different lines of insurance.

It is also the case manager's responsibility to make assessments and recommendations on an objective basis, having no vested interest in which rehabilitation facility or infusion service is selected. If it seems that case managers are held accountable not only for their academic credentials and work history, but also for their personal ethics, it is because they are. Often functioning without peer support or direction from an immediate supervisor, case managers must bring their own motivation, moral strength, independence, and confidence to each case. This is the personal profile needed to oversee a wide spectrum of activities with the sole focus of ensuring the best possible outcome for a patient in the most cost-effective manner.

The current nursing shortage has been widely reported; the need is estimated at 526,800 due to growth and replacements, for a total of 3.2 million RNs by 2022.¹ In this same report from the Bureau of Labor Statistics' Employment Projections 2012–2022, released in December 2013, the RN workforce is projected to be the top occupation in terms of job growth, expanding by 19 percent from 2012 through 2022.²

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and the subsequent enrollments, more than 47 million individuals now have access to healthcare services, and although there has been an increase in the number of entry-level baccalaureate nursing programs, the shortage of nurses will likely continue for the foreseeable future. The reasons for this are understandable: a shortage of qualified faculty, the average age of nurses climbing, an aging patient population, and the ongoing departure of practitioners from the profession. The impact is resulting in troubling consequences, not the least of which is unsafe patient care. Nurses are working more overtime or double shifts and are responsible for a greater number of patients than before, meaning they have less time to spend with each patient and to complete all their tasks to the standards they feel are important to maintain. Turnover is increasing, especially among more experienced nurses. Many hospital nurses

are concerned that these conditions have the potential to affect their early detection of patient complications and their ability to maintain patient safety.

In this environment, the case manager's role becomes increasingly significant to ensure appropriate, quality care. Case management intervention addresses the needs that arise as hospital staff, for example, is stretched to capacity. Conversations between case managers and acute-care nurses were never relaxed coffee klatches, but now they have become even quicker exchanges. To obtain background information that might not have been communicated verbally, case management staff has begun looking more closely at nurses' notes, especially when the things they hear don't match up; for example, the patient says he is fine but is experiencing complications. The insights gained from these notes, where treatment changes and patient reactions are recorded, enhance our ability to spot potential problems or a lack of progress so we can intervene and redirect as necessary.

Aware of the higher possibility of infections due to understaffing, a case manager will be more proactive and assess skin integrity, on-site or through conversation, to avoid the development of decubitus ulcers. On behalf of a stroke patient, a case manager might ask if hand splints are in place to prevent contracture, which would decrease hand mobility and a return to strength.

Exacerbating the shortage, hospital-based RNs have also become more involved in and accountable for activities not associated with patient care, such as budgets, coding meetings, staffing issues, and usage of quality improvement tools. Each of these is of value to hospital administration but does not contribute directly to patient care.

Similarly, case managers are vulnerable to revisions of their job descriptions and responsibilities as hospitals and healthcare organizations face both economic stresses and this shortage of qualified nurses. In an article in *The Case Manager*, trends noticed by Case Management Society of America (CMSA) members included the delegation of clerical responsibilities to case managers, delegation of patient interactions to non-case managers, an increase in the clinical condition responsibilities that now fall to case managers, and a rise in caseloads.³ (A closer look at changes in caseloads is documented in the "2015 Case in Point Salary & Trends Special Report.") Each of these undermines case managers' roles by drawing them away from patient advocacy and care coordination across the continuum, siphoning off their time with secretarial duties, or loading up their work responsibilities so that rushing through each task is the only way to complete them all. This lessens the value and effectiveness of their contributions and opens the door for complications. Would anyone knowingly hurry an analyst through reading a sonogram or a breast X-ray?

THE CASE MANAGER'S ROLE

Case managers are not claims police. Ensuring cost-effective treatment does not mean that case managers are overrated number crunchers who review treatment alternatives simply to find the cheapest scenario. Case managers are coordinators, facilitators, impartial advocates, and educators. Their roles are as varied as the sites where they are employed and the job titles that designated their position in the past.

A case manager in an acute-care facility may have been called a discharge planner a few years ago. In behavioral health facilities, the program coordinator or coordinator of patient services may now carry the title of case manager. Transition care manager, health advocate, health navigator, professional patient advocate, and guided care nurse are just a few of the still-evolving titles. Regrettably, there are now so many titles for those providing these services that it not only has contributed to confusion by its recipients, but it also might decrease the recognition and influence case managers have in the future.

Case managers in hospitals, rehabilitation facilities, nursing homes, long-term care and assisted living settings, home health agencies, and infusion care companies are in the provider sector of health services and may include nurses and social workers. More and more, we are seeing case managers embedded in primary care practices as well, contributing to a decrease in avoidable hospital admissions. They may oversee treatment while a patient is in a particular facility or receives a certain type of service, such as infusion therapy, but not be involved with that same patient's care when the patient moves on to a different center or care program. Depending on the employer, a case manager may never make a home visit or manage care outside of a particular facility.

In the payer sector, both public and private, case managers may work through third-party administrators (TPAs), self-administered programs, health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service (POS) plans, military programs, or major insurance carriers. In these settings, case managers identify and track all hospital admissions and other events in which there is a likelihood of costly or high-exposure conditions. Although the employer emphasis may seem to be on reducing overall costs, these case managers are also dedicated to assisting employees and their dependents in the utilization of services.

Because of financial organizational structure and administrative overhead, many organizations do not elect to maintain an in-house case management department or staff. This, coupled with the direct-to-consumer trend, is behind the growing and diverse opportunities for independent case managers. Those with strong expertise in neonatology, oncology, elder care, or organ transplants may find heightened demand for their services. One such source is stress-ridden baby boomers who call on independent case managers on behalf of their aging parents.

Independent case managers are outside both the medical care provider and the claims-payer systems. All case managers are charged with the responsibility to make totally objective assessments and to coordinate a program of care. With no vested interest in the companies selected to provide this care or services, independent case managers can be impartial advocates for their clients and may have an advantage in exercising out-of-the-box thinking and solutions.

The focal point of case management in all its roles is to empower patients, giving them and their families access to a greater understanding of their disability or disease, a larger voice in the delivery of their care, and more personalized attention to their particular needs. Obtaining data on the particulars of each patient's case, case managers enable patients and their families to make informed decisions. Through their role as advocates, they help patients deal with the complexities of the healthcare system.

CASE MANAGEMENT IS NOT EQUIVALENT TO MANAGED CARE

Managed care and case management are not interchangeable concepts. Managed care is a system of cost-containment programs; case management is a process. As a global term, *managed care* consists of the systems and mechanisms utilized to control, direct, and approve access to the wide range of services and costs within a healthcare delivery system. Case management can be one of those mechanisms; it is one component in the managed care strategy.

Based on the use of cost-containment programs that include guidelines and criteria for healthcare delivery, managed care organizations (MCOs) incorporate a wide variety of options. These may include pharmacy benefits management (PBM), POS plans, consumer-driven plans, HMOs, PPOs, direct contracts (in which an employer contracts directly with a hospital or other healthcare facility), bill audits, utilization review, preadmission authorization, concurrent review, retrospective review, second surgical opinions (SSOs), independent medical exams (IMEs), disease management, and case management. Whereas managed care programs strive to involve all potential users of healthcare services, case management focuses on certain individuals—the 3 to 5 percent of the patient population responsible for 60 to 70 percent of the expenditures in any health plan.⁴

Case management is a highly individualized process that aims to identify the most at-risk, vulnerable, or care- and cost-intensive patients; assess treatment options and opportunities to coordinate care; design treatment programs to improve quality and efficacy of care; control costs; and manage patient care to ensure the optimum outcome. Concentrating, for the most part, on catastrophic or chronic cases, case managers are called on to consult for diagnoses such as head injury, multiple trauma, cancer, AIDS, organ transplant, cardiovascular and respiratory disease, stroke, burns, spinal cord injury, premature infants, diabetes, and high-risk pregnancy.

According to the 2014 Towers Watson/National Business Group on Health “Employer Survey on Purchasing Value in Health Care,” employers’ costs are continuing to rise as healthcare costs outpace inflation. At the time of the survey, employer costs were expected to reach \$9,560 per employee, up 4.4 percent from 2013. At the same time, the employees’ share rose nearly 7 percent (expected to be \$2,975 per employee) from a year ago, as more companies continue to shift some of the burden of healthcare costs to employees.⁵ Other surveys report similar findings.

In its 2013 survey of 2,842 employer-sponsored health plans, Mercer Health & Benefits found that case management was the leading cost-containment strategy among large-employer plans (more than 500 employees), with 82 percent of these companies utilizing it.⁶ Although these surveys certainly underscore the increase in costs over the past several years, the future poses even more concern as employers address the cost implications post-ACA legislation. The 2013 Mercer survey cited a few of the more significant concerns: the requirement to extend benefits to employees who work more than 30 hours per week and the resulting wild card number of new enrollees in their healthcare plans.⁷ Mercer’s 2015 “Health Care Reform Five Years In” survey of nearly 600 employers answered one of those unknowns: the average percentage of full-time and part-time employees enrolled in employer-sponsored

health plans remained virtually unchanged between 2014 and 2015.⁸ As employer organizations continue to grapple with these unknowns, most assuredly a bigger focus will be on cost-containment strategies and, hopefully, a brighter spotlight on case management.

The trend toward greater use of case management is not new. In its 1996 Executive Opinion Poll (which introduced a new survey design and methodology), *Business & Health* asked respondents to name the management techniques applied by their healthcare plans from a list including case management, utilization review, disease management, demand management, pharmacoconomics, and outcomes research. Outcomes published in “*Business & Health* Executive Opinion Poll—1996” showed case management leading the other categories as the management technique most used by healthcare plans of large and small companies combined. In a note that should have been a wake-up call to chief executive officers (CEOs), even as it warmed the hearts of TPAs and insurers nationwide, the report mentioned that a substantial portion of respondents did not know whether a particular technique was utilized by their healthcare plan. This reinforced my concern (and continued amazement) that the majority of employers (those who ultimately pay for employees’ healthcare coverage) do not know how that money, that resource, is being managed.

In 2005, URAC (originally incorporated under the name Utilization Review Accreditation Commission, shortened to URAC) conducted a national survey of more than 282 companies regarding trends and issues in medical management. Participants included HMOs, PPOs, stand-alone medical management companies, insurance carriers, and others. The study researched national trends and issues in medical management, and the article “Converging Pathways: A Journey Towards Quality Case Management” reported that more and more companies were employing a combination of utilization management, disease management, and case management.⁹

Since the passage of the ACA, employers have become increasingly more keen to manage their healthcare dollars and more aware that certified case managers (CCMs) are effective in helping to accomplish this. According to the Commission for Case Manager Certification’s (CCMC) *2014 Role and Function Study*, a greater percentage of employers—40.2 percent—now require that the case managers they hire be certified, a 14.7 percent increase from 2009.¹⁰ Additionally, other findings from that study will continue to shine a spotlight on case management. There are new regulations and payment codes (Current Procedural Terminology, or CPT) that specifically authorize reimbursement for care coordination, care management, and transition of care activities—all within the scope of case management. And, as might be expected with this recognition and reimbursement (pay for performance), there will be an even greater demand for case managers to be able to measure the value and report the outcomes. The success, or lack thereof, of case management may not only result in a reward, but in the case of an avoidable readmission it may result in a penalty for the organization. Of interest as well, ethics, legal, and practice standards were elevated to increased importance as knowledge required of case managers, likely attesting to the complexity of case management today.¹¹

Case managers have long expressed that the benefits of combining case management, utilization review/utilization management, precertification, and newer concepts in health care, such as disease management and wellness promotion, can be achieved when provided

in a coordinated system. This integrated provision of strategically designed services can achieve the best outcomes for patients and limit employer and payer risks. Now it seems that this type of system is becoming a reality.

The positive piece that all case managers can embrace is that, within this comprehensive study, case management is perceived as a distinct role and function that is best applied in a coordinated program with utilization management, disease management, discharge planning, and social work. Still, this collaborative model can be improved upon, and more information about case management needs to be communicated.

MEDICAL CREDENTIALS AND EXPERTISE

Agreed-upon credentials and criteria for what makes a good case manager and the level of preparation required to handle the usual responsibilities have long been established as part of the development of the CCM and other case management credentials. Predictably, the criteria caused an outcry from some individuals who claim to offer case management but discovered they are worlds apart from case management practitioners who are eligible for certification. For example, there are individuals currently working as case managers who have no more experience than 1 year in a hospital and a weekend-obtained certificate in case management. Case management as a profession demands critical thinking skills, in-depth clinical knowledge, and extensive, diversified experience within the healthcare delivery system. It is an advanced practice, and, as such, it requires a high level of knowledge and competency.

Today's case managers come from diverse educational and clinical settings, many with broader backgrounds than a strict hospital environment. Generally, they are nurses, social workers, or rehabilitation counselors, and a number of them have had experience administering workers' compensation and disability cases involving catastrophic injury. Far beyond helping an individual recuperate and return to work, case managers address health and wellness within disease management and wellness programs, as well as the needs of those already experiencing costly medical conditions and their complications. They assist in everything from tertiary neonatal cases, premature babies, and healthy baby programs to geriatric cases, stroke victims, and living with diabetes. There is a need for broad clinical knowledge and standards of care for less complicated conditions, and on to kidney failure and amputations, which is causing subtle shifts among case management practitioners.

Social welfare caseworkers, involved with programs like Medicare, originated some elements of case management procedures. They developed and perfected the skills involved in connecting people to their community resources and obtaining financial aid from federal and state agencies. Social workers will undoubtedly continue to make up a substantial portion of case managers. Although considerable supplementary training and experience might be required before they could manage complex medical cases, such as ventilator-dependent babies or an individual requiring infusion services, social workers with medical backgrounds can handle stable cases and provide assistance to our fast-growing "gray" population. They also play a significant role in behavioral health programs. And combining social workers and RNs in medical case management teams has already proven very effective, enabling

speedier identification of solutions to patient problems. As professionals with a different focus, rehabilitation counselors have also become valuable members of such teams, with their emphasis on recuperation and the return to work. The diversity of healthcare professionals (i.e., nurses, social workers, counselors, pharmacists, and others) working collaboratively certainly lends itself to the highly desirable integrated model of case management, which is increasingly sought today in many practice settings.

Because of the medical problem solving and coordination responsibilities inherent in the case management role, the kind of experience and education that nurses possess becomes important. In addition to basic educational preparation—associate degree, diploma school, or baccalaureate level—life experience counts for a great deal. But case management demands a greater depth and intensity of involvement than traditional nursing, as well as more advanced medical, psychological, and sociological training. Therefore, a case manager's educational process should be ongoing and, through continuing education studies or postgraduate work, should be directed toward achieving a master's degree in a clinical specialty, for example. Because continuing education is not mandated for updated RN certification in many states, a number of practicing case managers neglect their obligation to remain current in their field. Those selecting case management as a career owe it to their patients, their profession, and themselves to read, attend conferences, and sit in on seminars and lectures to broaden their knowledge base. The CCM designation requires case managers to take advantage of continuing education to maintain their credential status, as does the Accredited Case Manager (ACM) from the American Association of Case Managers, the Case Manager Associate (CMC-A) from the American Institute of Outcomes Case Management (AIOCM), the Certified Social Work Case Manager (C-SWCM) designation from the National Association of Social Workers, the Registered Nurse-Board Certified (RN-BC) from American Nurses Credentialing Center, and many others.

Due to the tendency of multiple conditions, sometimes comorbid, in the case management patient population, the kind of clinical experience of greatest value is that of a generalist. Although there are case managers with a single practice area, such as those who specialize in high-risk neonates, head trauma, organ transplants, oncology, or hematology, most case managers should have experience with a variety of age groups, treatment facilities, and medical conditions. The majority of case managers will receive referrals requiring knowledge of a wide spectrum of medical practice specialties, and they will need to acquire a diversified clinical background to meet the challenges. Ideal clinical preparation includes in-depth exposure to medical-surgical treatments, intensive care, critical care, home care, psychology, obstetrics, pediatrics, and neurological care. Case managers must be able to distinguish good care from bad care, understand potential complications, and evaluate alternate treatment options. Working in one hospital unit for 1 year does not provide the range of cases and insight required of a good case manager. Even comprehensive hospital experience alone is insufficient preparation. In most hospitals, equipment and supplies are readily available. Leaving the safety and support systems of the hospital environment, we can appreciate how vulnerable our patients can become when necessary services are fragmented. Further, case management requires self-direction, critical thinking, and independent functioning and judgment, skills honed more readily in nontraditional healthcare settings. Experience in

home health care, walk-in clinics, and occupational health nursing can provide a beneficial view of community healthcare options.

Because the work requires financial savvy, a business background is also helpful. Hospital nurses do not have to cost out the care they are administering, but case managers must be financially accountable. If they cannot demonstrate the positive impact of case management to its stakeholders (payers, providers, patients), case managers undermine the value of their industry and, therefore, their future. They need to know, for example, the cost of infusion care treatment so they can question payment on a creatively submitted invoice. Forget that they can help improve employee morale, help a disabled person get back to work faster to continue a rewarding career, and locate an appropriate facility 10 miles from home rather than 550 miles away for a child with a head injury; if they cannot combine their healing skills with practical business skills, they will lose the opportunity to practice.

Case management work often places individuals in situations in which patients and their families are devastated by health-related problems. Beyond facilitating healthcare decisions on behalf of other human beings, case managers also face the type of intense social–dynamic family issues that never become easy to handle but can be approached with more empathy and grace by practitioners who have become acquainted with the emotions encountered in marriage, divorce, illness, and death. Less experienced practitioners are likely to have difficulty appreciating the significance of such issues. Five or more years of clinical experience helps develop a maturity and depth that makes it easier to relate to patients and understand their emotional state.

Case managers need personal stamina and strength. Most caseloads include tragic cases. Case managers cannot make a terminal illness fade away. They cannot fully empower a patient if the family is too broken to accept the necessary responsibility. Case managers, therefore, need personal resources and support from friends and family to meet the challenges each day will present. A can-do mentality, a ready sense of humor, and the gift of levelheaded self-affirmation to take personal note of small successes every day are among the traits that boost a case manager’s effectiveness.

A DEFINITION OF CASE MANAGEMENT

The CCMC (www.ccmcertification.org) defines case management as follows: “Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the 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.”¹²

The CMSA (www.cmsa.org) defines case management as “a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.”¹³

As one can appreciate, the aforementioned definitions, although professional and descriptive of the process, would be a bit overwhelming to patients, their families, and even some of our colleagues in health care. We did not want to create a barrier to the introduction

and hopeful acceptance of our intervention, so case managers came together via another organization under the auspices of CMSA: the Case Management Leadership Coalition. After a review of 150 definitions, the organization adopted the following consumer-friendly definition, which was then translated into eight different languages and made available on their website: “Case managers work with people to get the health care and other community services they need, when they need them, and for the best value.”¹⁴

This definition could easily be utilized in marketing materials, on websites, and on the back of a case manager’s business card to communicate and promote the visibility and acceptance of our services.

Although it is not in all language referring to the role and function of case managers, and it is not possible in all settings, for all case managers I would add that case management is most effective when it is provided across the continuum of care. When a case is opened and then worked as the patient moves from an acute-care hospital to a skilled nursing facility or rehabilitation center, and then home, case management can offer its greatest contributions to quality health care and the best use of healthcare dollars.

In the broadest sense, a case manager is the person who can make the healthcare system work, influencing both the quality of the outcome and the cost. In our country, healthcare delivery is fragmented and complex. Providers range from walk-in clinics to exclusive provider organizations and centers of excellence, and care settings run the gamut from a patient’s own bedroom, up through rehabilitation facilities, outpatient facilities, specialized long-term care sites, and nursing homes, to hospices, subacute-care facilities, and hospitals. It is no surprise that patients are confused.

Working as an advocate for patients (always searching for and moving toward the most medically appropriate solution), an empowering agent for families, and a facilitator of communication among patients, families, care providers, and payers, the case manager is a sentinel for quality assurance and cost effectiveness. Perhaps the case manager can affect an earlier discharge, negotiate a better fee from a medical equipment supplier, or encourage the family to assume responsibility for a portion of the day-to-day care the patient needs. She can be a catalyst for change by seeking solutions that promote improvement or stabilization rather than simply monitoring patient status. If the case manager performs all these functions well, quality assurance and cost savings fall into place as a matter of course, prolonging the life of benefit dollars for individuals and helping to free up healthcare monies for the 29 million uninsured individuals in the United States during the first 3 months of 2015, according to the National Center for Health Statistics.¹⁵

CASE MANAGEMENT ROLE AND FUNCTIONS

To be effective, case managers require broad-based knowledge. They need to be part general practitioner, part social worker, part psychologist, and part minister or rabbi. Even if the case management role never requires going beyond the boundaries of this specialty, a case manager needs to be aware of the psychosocial, environmental, family, economic, and religious dynamics that can impact patients. She also must have a diverse medical background; being a clinician is not enough.

Areas of general knowledge and the understanding of healthcare treatments and systems required by case management practitioners were encompassed in the preliminary 1992 CCM credentialing report. Suggested general knowledge included theories of family functioning; the characteristics of various stages of physical and psychosocial development; the traits of functional and dysfunctional coping and their implications for health; and resources, eligibility for services, and referral procedures. In the area of health care, first-draft credentialing criteria called for comprehension of “home health resources; strategies to access medical records; medical terminology; pharmaceuticals and pharmacological management; levels of care in acute and rehabilitative treatment; adaptive equipment and assistive devices for various disabilities and illnesses; issues involving experimental treatments and protocols; and competitive cost for medical and healthcare services, aftercare, and independent living resources,”¹⁶ in addition to other healthcare factors. Because of the case manager’s role as a communicator and liaison, she must also be familiar with certain elements within the insurance, legal, and vocational disciplines. For example, to interact successfully with insurance and funding sources, a case manager must be facile with insurance terminology, the preparation of cost–benefit analyses for payers, the reporting requirements of various healthcare reimbursement and government agencies, disability compensation systems, extended medical or indemnity payments, and coordination of benefits. To practice ethically and safely, a case manager should also be familiar with legal terminology, liability issues, use of depositions, confidentiality laws, and the accepted procedures and requirements for releasing or sharing information. To best meet patient needs, one must be familiar with cultural issues, complementary and alternative care, herbal medications, end-of-life concerns such as pain management, and specialty areas of case management. And finally, vocational and legislative protocols will govern care options and benefit plan dollar availability for some individuals. These areas of knowledge will encompass resources for reentry into the labor force, work evaluation processes, job accommodation principles, affirmative action, the philosophy of workers’ compensation, the Americans with Disabilities Act (ADA) of 1990, Medicaid and Medicare provisions, and the rights of individuals under federal and state law (both the state in which a case manager practices and the state in which a patient is undergoing treatment).

All this said, it must also be noted that case management is usually not a hands-on role. Case managers, while continuing to be actively practicing nurses, clinicians, or caregivers, do not diagnose an ailment, prescribe a medication, or set the course of treatment. They do offer their observations on a patient’s status and use their expertise to plan and suggest alternative care options. Using on-site visits as fact-gathering missions, a case manager can make sure a noncompliant patient is following the treatment plan outlined by the physician or note the possible complications from the medication recommended by an ear-nose-and-throat specialist but never mentioned to the cardiologist. Case managers are consultants, advisors, and facilitators.

Although the majority of case managers do not offer hands-on care, neither can they be truly effective if they act in a totally hands-off manner. Telephone work, which is a part of case management, is necessary for keeping the lines of communication open without driving up costs. It is particularly effective for preventive and case-screening measures as well as for tracking low-intensity patients or patients whose conditions have improved to the point

where in-person case management is no longer needed. However, strict telephonic case management, in which all the communication between the case manager, patient, family, physician, and payer occurs over the phone, can lead to major oversights in care unless skillfully conducted, especially in cases in which the patient is noncompliant, undereducated, or poor. The vulnerability of the patient, combined with the legal and monetary exposure of the case manager, provider, and payer, often necessitates on-site interaction.

Case managers fulfill a role not provided for elsewhere in the healthcare system. They become the eyes and ears for others, a resource for physicians and other members of the healthcare team, insurance groups, employers, and particularly families. Because people tend to picture described situations in terms of their own experience, they tend to make incorrect assumptions. A telephonic case manager might envision a patient's home as complete with a stocked refrigerator, adequate room for a ventilator or a motorized wheelchair modified with respiratory equipment, and clean sheets on the bed. During an on-site home visit, a case manager will be able to note the empty refrigerator, the two toddlers careening around the couch and bumping into the infant's oxygen supply tubing, the unopened medication bottles, and the family in need of respite.

Let's review a real case in which a gentleman suffered a left-sided stroke that left him with right-sided weakness. The physician assured the case manager that the patient was fine upon discharge and did not require any equipment or support services. The case manager never asked the patient, Can you walk comfortably? Will you need a cane for support? Will you be able to walk around inside your home? In the weeks following discharge, the man experienced complications and difficulty maneuvering around his house. His wife was upset with the case manager and the physician for their lack of support. A more complete telephone conversation and the appropriate follow-up calls would have solved these problems. (For more information on telephonic case management, please see Chapter 3.)

Beyond the medical aspects lies another whole dynamic of an illness: the logistics of coping, which might require putting a caretaker's job on hold or a home up for sale. Here is where a case manager can help fill a void in the system by assisting the well persons in the family in dealing with practical matters. A comatose patient does not need hand-holding, but the caretaker in the family might—or might need guidance from a person who can fully explain treatment options, a safe person to share emotions with, or someone to fill out forms and help file claims. When the claims department returns a form marked “incomplete,” there is no note describing what information was omitted. Unfiled claims cannot be reimbursed, and the case manager can be the person to help pull the details together, to get the burned-out caretaker some part-time assistance, or to call the bank and request a payment plan for the home mortgage.

Again, after a basic assessment of the patient's condition and family and home setting has been completed, the case manager has established his or her role with the patient, treating physician, and nurses, and has set up the services to match the resources and needs of the patient and family, then the telephone can become a tremendous resource. The moment a case manager hears something during a telephone conversation that sets off an internal red alert, an on-site visit ideally should be made. If the assigned case manager cannot accomplish this due to a geographic or other restriction, and especially if patient safety and/or liability is an issue, then a home care nurse can serve as valuable eyes and ears.

CERTIFICATION, ACCREDITATION, AND STANDARDS OF PRACTICE

The CCMC publishes the *CCM Certification Guide*, revised periodically to meet the changing roles of case managers in numerous practice settings within the evolving managed care industry. Every 5 years, representatives from the entire field of case management practitioners across the continuum of care are canvassed, and their conclusions are incorporated into the CCM exam content and credentialing criteria, leading to appropriate updates in the CCM role and function information. In this way, the CCM exam remains an accurate reflection of the field. The results also indicate areas in which case managers might require additional educational support and reference materials.

The CMSA developed the first set of *Standards of Practice for Case Management* in 1995. In 2002, it became apparent that an update was needed to bring the standards in line with the evolution of the case manager's role, the process of case management, and practice settings as the healthcare delivery system changes to meet our times. Following a rigorous peer review of the standards, public comment, and research, drafts and final versions were developed. Several years later, in 2010, another revision occurred, and the *Standards of Practice for Case Management* was published again. It lists the primary case manager role functions as assessment, planning, facilitation, and advocacy.

URAC, a leader in the accreditation of healthcare and MCOs, has created the *URAC Case Management Core Standards*, which also speaks to case management staff development, organization ethics, processes, and other issues that are involved in the provision of case management services. Taken together, these three new documents offer a comprehensive, detailed description of the case manager's purpose, goals, role, function, experience, performance indicators, and more. The CCMC certification guide provides insight into the kind of education, clinical preparation, and life experience that will most benefit a case manager. The guide's "Licensure/Certification Requirements" section includes the eligibility standards, education, licensure, and certification criteria that applicants for the CCM credential must satisfy prior to sitting for the CCM examination.

In addition to CCMC's education, licensure, and certification criteria, applicants must meet the qualification of one of three employment experience categories. Category 1 calls for "12 months of acceptable full-time case management employment experience supervised by a Certified Case Manager (CCM). Supervision is defined as the systematic and periodic evaluation of the quality of the delivery of the applicant's case management services." Under Category 2, "24 months of acceptable full-time case management employment experience" is required. Supervision by a CCM is not requisite in this category. Category 3 lists employment experience of "12 months of acceptable full-time case management employment experience as a supervisor of individuals who provide case management services."¹⁷ Verification of this status varies.

According to the *CCM Certification Guide*, applicants must perform services that encompass the essential activities of case management, including assessment, planning, implementation, coordination, monitoring, evaluation, and outcomes, and be able to demonstrate that they apply these essential activities within at least five of the six core components of

case management (case management concepts, principles of practice, psychosocial aspects, healthcare management and delivery, healthcare reimbursement, and rehabilitation) across the continuum of care that matches the ongoing needs of the individuals being served, with the appropriate level and type of health, medical, financial, legal, and psychosocial care. The employment experience regarding core components must also involve interactions with relevant components of the individual's healthcare system, such as physicians, family members, third-party payers, and other healthcare providers, and deal with the individual's broad spectrum of needs.¹⁸ It delineates processes and services that clearly demonstrate the provision of case management activities applying the essential functions across five of the six core areas beyond a single episode of care.

To enhance the accountability, recognition, and professionalism of case managers, certain initiatives were developed over time by individuals and organizations. Standards of practice, a code of professional conduct, accreditation of organizations, and certification of professionals are just a few. Alongside the CCM credential, there are several other popular case management credentials. (See Chapter 14 for further information on credentials.)

THE PROLIFERATION OF NEW TITLES ENCROACHING ON THE CASE MANAGER'S ROLE

An unfortunate trend has taken hold in the case management profession. It does nothing to help build credibility, stature, and understanding of the role and value of case managers. Instead, it has the opposite effect. Specifically, the proliferation of countless titles to describe functions that are all encompassed in the role of case managers is causing a serious identity crisis. Functions that are performed under case managers are now being assigned to individuals who hold titles ranging from care coordinators, care managers, patient advocates, and health navigators, to disease managers, health coaches, and, yes, case managers. Further complicating the matter are provider organizations and plans that confine the role of a case manager to a specific function, such as disease management or utilization management. Other entities may title an individual a health manager and place him or her in charge of caring for patients with certain conditions, such as chronic obstructive pulmonary disease (COPD), cardiac conditions, or diabetes. The effect of the excessive titles and this fragmented approach is confusing for patients, their families, and other medical professionals, and it is an erosion of the full extent and value of case managers' roles.

Adhere to Code of Professional Conduct and Standards of Practice

There are different certifying bodies and professional organizations that define the scope of case management and its functions. The CCMC and the CMSA are the two primary organizations.

The CCMC is the first and largest nationally accredited organization that certifies case managers. It has established a "Code of Professional Conduct for Case Managers." The CCMC developed a definition of case management that is presented in its "Scope of Practice for Case Managers." The CCMC defines case management as follows: "The practice of case

management is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim,' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care."¹⁹

The CMSA defines itself as "the leading non-profit association dedicated to the support and development of the profession of case management."²⁰ On its website, the CMSA discusses the type of work case managers do as assessment (i.e., identifying the condition–needs, abilities–preferences of the patient leading to the development of a plan of care), care planning (i.e., defining strategies and steps toward achieving desired outcomes), alignment (aligning the plan of care parts and putting it into action with the patient), evaluation–outcomes measurement (i.e., determining what is and is not working in the plan, where modifications need to be made, and what progress is being made), and promoting self-determination (i.e., providing the patient with skills needed for self-management and self-care).²¹ The CMSA also defines what it believes case management is not. Included among the functions it excludes are benefit determination, utilization management, administrative tasks, risk management, and direct patient care not related to case management assessment and intervention.²²

Another organization under which nurse case managers gain a professional credential is the American Association of Managed Care Nurses (AAMCN). The AAMCN has Practice Standards and a Certification in Managed Care Nursing (CMCN) credential held by many nurses serving as case managers. Its mission is "to be recognized as the expert and resource in managed care nursing; to establish standards for managed care nursing practice; to positively impact public policy regarding managed healthcare delivery and to assist in educating the public on managed care."²³

Within these organizations alone, there is a lack of consistency that further gives rise to the use of different titles and the fragmentation of the role of case management. This is despite the fact that each organization has developed guidelines for their definition of case management and professional conduct expectations of case managers who hold their credential, as in the case of CCMC and AAMCN, or who are members, as in the case of CMSA.

The Fallout from Role Fragmentation

What the wide range of titles has done, both deliberately and inadvertently, is to fragment the role of case management. This, in turn, diminishes the stature of case management professionals. It conveys to the broader healthcare community that the entirety of what case management encompasses does not matter and that the role can be divided with no negative results. This cannot be further from the truth. The more dispersed case management becomes, the less value it holds and the less visible it becomes. For patients and their families, this can have devastating results in terms of having even more professionals involved in their health care with potentially less accountability and more confusion. For case managers, the proliferation of titles and role fragmentation will lead to a less fulfilling and less prosperous career path. Eventually, fewer nurses will enter the field, leading to a shortage of certified qualified nurse case managers, a void in patient care, and lapses in performance in our new era of value-based health care.

Stand By a Singular Definition of Case Management

To diffuse and eventually halt the widespread use of multiple titles and practice of fragmenting case management, there must first be a broad consensus regarding the definition of case management, such as the one put forth by the CCMC. Case management tasks must then be assigned only to individuals who have the education and professional credentials, including certification, and who rightfully should be titled case manager. Avoiding the use of any other titles for individuals whose functions fall under the scope of a professional case manager's role is imperative. This will significantly lessen the confusion among providers, insurers, employers and other plan sponsors, and, most importantly, patients and their families who are calling for simpler, more accountable, high-quality healthcare.

NOTES

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