Chapter 3

Psychosocial Aspects

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Psychosocial is a term that is understood by all but can be difficult to define in a manner that is specific to our role as case managers. Generally, psychosocial refers to the interrelation of social factors with an individual's health, thoughts, and behaviors.

As case managers, we endeavor to advance the quality and the appropriateness of care to the clients we serve. In seeking that goal, our body of knowledge cannot be solely focused on the muscles, bones, and organs that comprise our client's physical bodies or the pathology of the diseases that impact our client's health. To be efficient and effective in the delivery of our interventions, case managers are charged with embracing a holistic approach of service delivery that advances the attainment of client-centered and desired goals.

Case managers utilize various processes to foster a comprehensive understanding of our client—body, mind, environment, and family—in order to achieve our mission of supporting the client through and across each transition of care. Recently, the term *biopsychosocial* has been added to the case management vocabulary to represent the significance of the interplay among the medical/biological, psychological, and social influences that impact health and wellness.

A Role and Function Survey performed by the Commission for Case Manager Certification (CCMC) identified "the increasing complexity of clients' needs across the health care continuum and the expanding dimensions of transdisciplinary health care team." Based on that study, an increased focus on psychosocial concepts and support systems was incorporated into the current Certified Case Manager examination. The following topics have been identified by CCMC as key knowledge areas associated with known psychosocial concepts and support systems.

ABUSE AND NEGLECT (E.G., EMOTIONAL, PSYCHOLOGICAL, PHYSICAL, FINANCIAL)

According to the Standards of Practice for Case Management (SOP) as presented by the Case Management Society of America (CMSA), the key philosophical components of case management "address care that is holistic and client-centered, with mutual goals, allowing stewardship of resources for the client and the health care system". The central concept presented in this statement is the advocacy aspect of case management. Without advocacy, case management becomes little more than resource management and that focus does not address the human burden of disease.

As case managers partner with clients and their families or support systems, the case manager may identify both the advantages the client might experience by being part of a family or community and the challenges that might arise when that family or community does not respect or support the client. One form of disregard, contempt, or disparagement of or for the client is abuse.

Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting pain or mental anguish or the willful depreciation by a caretaker of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. Neglect is a form of abuse that includes the failure to provide the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. Abuse or neglect can be physical, emotional, or financial and may include:

- Child abuse or neglect
- Medical neglect
- Elder abuse in the community or residential environments of care
- Domestic violence
- Sexual abuse or exploitation
- Financial abuse

Emotional or psychological abuse includes any act including confinement, isolation, verbal assault or aggression, humiliation, intimidation, or any other treatment that may diminish a person's sense of identity, dignity, and self-worth. While the evidence of physical abuse can be recognized through physical examination, psychological abuse may be more difficult to identify. Specific forms of emotional abuse might include insults or name calling; threats or intimidation; ignoring or exclusion; mocking or humiliating. The abuser may deny the infliction of abuse or blame the person abused for prompting abusive behaviors.

Self-neglect represents a client's inability to perform essential self-care tasks due to physical and/or mental impairments or diminishing capacity including the provision and use of food, clothing, shelter, and health care. If the client has the capacity to formulate and implement a decision that might contribute to self-neglect, the case manager respects that decision while offering information regarding resources to address that neglect. However, in situations in which a client has a diminished ability or capacity to make and implement decisions regarding physical and emotional needs, it is the responsibility of the case manager to advance the steps necessary to promote enhanced care and protection for that client.

While clients may have the decisional capacity for choosing components of care, they may not demonstrate an ability to execute the delivery or implementation of steps necessary to advance self-care and self-protection. In cases of abuse, neglect, or self-neglect,

case managers are guided by legal, professional, and regulatory mandates for reporting suspected abuse or neglect. Additionally, the Standards of Case Management as presented by the CMSA support a comprehensive client assessment that addresses substance use and abuse, a history of abuse or neglect, and any safety concerns associated with a history of neglect or abuse.

In addition to reporting suspected abuse, neglect, or self-neglect, the case manager partners with other members of the interdisciplinary team to identify client-specific pathways to address any form of abuse and facilitate appropriate referrals to community agencies that might assist the client, family, or support system in addressing abusive situations.

Abused or neglected clients may develop post traumatic stress disorder (PTSD). PTSD is a debilitating condition that often follows a terrifying physical or emotional event causing the person who survived the event to have persistent, frightening thoughts and memories, or flashbacks, of the ordeal. Once considered a consequence of war and referred to as shell shock or battle fatigue, PTSD can be triggered by any terrifying event including sexual or physical abuse or assault, physical injury due to trauma, or natural disasters such as tornadoes, hurricanes, floods, or earthquakes. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma associated with PTSD generally results from an event, a series of events, or set of circumstances that are experienced as physically or emotionally harmful or life-threatening and that have lasting adverse effects on the individual's mental, physical, social, emotional, or spiritual well-being.

The signs and symptoms of PTSD may include:

- Reexperiencing symptoms such as flashbacks, nightmares, or terrifying thoughts
- Avoidance strategies including distancing oneself from places, events, or objects that are reminders of the traumatic event or experience
- Arousal or reactivity symptoms as represented by feeling tense or on edge, angry outbursts, or difficulty sleeping
- Cognition or mood symptoms evidenced by feeling guilt or blame regarding the event, loss of interest in enjoyable activities, or negative thoughts about oneself or the world. Some clients with PTSD may also have difficulty remembering aspects of the traumatic event.

Treatment of PTSD is generally associated with pharmacotherapy and counseling including group and individual therapies. Prescribed therapies may include cognitive therapies, exposure therapies, and eye movement desensitization and reprocessing therapies. Although the treatment plan for each client is unique, common case management processes exist to support the client who has been diagnosed with PTSD. Some of these case management activities include advancing medication adherence and persistency, ongoing assessment of the client's needs and adapting case management interventions to meet those unique client needs, and supporting interventions developed to assist the client to reduce symptoms and address any exacerbation in the disease state.

BEHAVIORAL CHANGE THEORIES AND STAGES

The role of the case manager as detailed within both the National Association of Social Workers (NASW) Standards for Social Work Case Management and the CMSASOP includes a focus on supporting the client to affect health behavioral change. NASW details an understanding of concepts and theories associated with behavioral change as knowledge

essential to the social work case management role. The CMSASOP's list is a set of guiding principles for a practice of case management that detail the integration of behavioral change science and associated principles throughout the case management process.

Behavioral change has numerous definitions, and the one frequently cited was presented by Prochaska and Velicer in 1997. Defining change as a process rather than an event, they detailed a transtheoretical model of health behavioral change that includes five distinct stages.

The stages of change model include:

Stage One—Precontemplation is characterized by denial or lack of knowledge regarding the problem or health issue the client is facing. This stage also includes clients who have previously tried to change and have failed, resulting in discouragement and rejection of the change process. If health behavioral change is necessary or desirable in order to advance a client's health or wellness, the client does not intend to take action within the foreseeable future. During this stage, the case manager might wish to offer the client information regarding the risks of the current behaviors and encourage self-analysis and introspection.

Stage Two—Contemplation is the active process of planning to change based on an awareness of the potential benefits that change brings as opposed to the consequences of that change. For example, the benefits of weight loss are desired but the steps necessary to obtain that loss such as reduced caloric intake are seen as a deviation and are, therefore, undesirable. This prompts ambivalence and conflicted emotions that may prevent the client from taking the steps necessary to fully realize behavioral change. Defined as chronic contemplation or behavioral procrastination, some clients continue to display this stage for long periods of time. Supporting the client during this stage of change might include assisting the client to consider the benefits and challenges of behavioral change as well as seeking to identify the primary barriers to change.

Stage Three—Preparation represents a stage of intending to initiate a move toward health behavioral change within the near future. The client may have developed a plan of action that advances their ability to make a lasting change in behaviors that might be considered unhealthy and move toward behaviors that support health and wellness. These clients may have already displayed small changes that may assist them in moving toward identified goals associated with the desired health behavioral change. The case manager might assist the client in identifying support groups and action-oriented programs that reinforce the steps necessary to achieve the change they seek to attain.

Stage Four—Described as taking action, this stage of change represents implementation of the necessary steps to affect health behavioral change and achieve the goals most closely associated with that change. Clients may fail in completing this stage not only due to the level of difficulty associated with executing the steps necessary to achieve desired goals but also because the client moved directly into this stage without consideration of the previous stages of change. During this stage of active change, the case manager might seek to motivate the client by recognizing goals achieved and by providing continued support of positive behaviors.

Stage Five—Maintenance is the stage in which clients are working toward the prevention of relapse, the successful avoidance of former behaviors, and the preservation of new behaviors. It has been estimated that this stage may continue from six months

to five years. During this final stage, the case manager might assist the client to develop strategies to avoid temptation or to utilize coping strategies for any situation or occasion that might encourage relapse. Clients should be congratulated for the changes they have enacted and supported in identifying triggers that might lead to relapse. An inability to successfully maintain health behavioral change can lead to a relapse that frequently fosters feelings of disappointment, failure, and frustration. Relapse is not generally considered a stage of change but rather a form of regression that results in a return to one of the previous stages of change.

TERMS ASSOCIATED WITH BEHAVIORAL CHANGE

Motivational Interviewing: Motivational interviewing (MI) is a "collaborative, person-centered form of guiding to elicit and strengthen motivation to change." (Rollnick, 2009) MI is also defined as a client-centered method of communicating in order to enhance the client's internal self-motivation to change. Health behavioral change is encouraged and facilitated by assisting the client to explore and resolve reasons for being ambivalent about or resistant to change.

Other terms associated with MI include:

Ambivalence: The client's experience of conflicting thoughts and feelings about a particular behavior or change.

Autonomy: The client demonstrates the freedom of choice to advance the steps necessary to affect change. The concepts of autonomy, competence, and relatedness are the foundation of the self-determination theory and represent:

- A rational client's capacity to originate and to control personal behaviors
- An ability to control the outcome and experience mastery over the health management process
- A desire to want to interact, be connected to, and experience caring for others

Evocation: The resources and motivation for change reside within the client. Motivation to change is enhanced by supporting the client's own perceptions, goals, and values.

Change-talk: The client voices the primary reasons for change. This might include considering what life might be like if change does or doesn't occur.

OARS: OARS is a mnemonic associated with a set of interactive techniques adapted from a client-centered approach that is based on MI principles. OARS incorporates both verbal and nonverbal responses and behaviors in a manner that is client-specific, culturally competent, and appropriate.

OARS includes four primary skills:

Open-ended questions—Asking open-ended questions seeks to establish a safe environment for clients to express their goals and concerns; to gain a greater understanding of the client's world; to understand the client's past experiences, feelings, thoughts, beliefs, and behaviors and advance the client's ability to make informed decisions.

Affirmations—statements offered to the client that build the client's self-efficacy. Self-efficacy is an ability to believe they can be responsible for their own decisions and lives. The purpose of using affirmations also includes: building rapport, demonstrating empathy, and affirming the client's past decisions, abilities, and healthy behaviors.

Reflective listening—requires careful listening, close observation of body language during face-to-face conversations, and reflection of the client's statement using your own words. Simple reflection is a repeating of the client's words. Another form of reflective listening is "rolling with resistance," which requires acceptance of the client's perspective.

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TERMS ASSOCIATED WITH BEHAVIORAL CHANGE *(continued)*

Summarizing—providing the client with a summary of the items discussed and the actions that the client has accepted. Summarizing keeps you and the client on the same page and allows for goal setting during the next call or conversation.

RULE

Another mnemonic associated with MI is RULE

Resist the righting reflex—As health care professionals, we often try to "fix" or "resolve" every challenge the client might be experiencing. Case managers do not seek to make things right for the client. We do not mandate change in our clients but rather empower, engage, and educate the client regarding his or her health, wellness, or disease state to support the client's intrinsic motivation to seek change.

Understand your client's motivation to change—Motivation to change is developed not by the case manager but rather the client. Our clients present with varying degrees of motivation for change. It is, therefore, necessary to understand your client's current state of desiring change and their anticipated future state for affecting that change. A simple method for evaluating readiness to change is asking the client simple open-ended questions that allow the client to express the level of willingness to change and the degree of confidence in his or her ability to achieve that change.

Listen—Listening skills are vital not only to MI but also to every aspect of the case management process. Assessment skills that are focused on asking open-ended questions are an important case management skill. Another vital skill is an ability to develop and utilize active listening skills to hear and interpret the information offered by the client. Engaged listening enables the case manager to more fully understand the client's motivation and readiness to change as well as the client's confidence in his or her ability to achieve the desired change.

Empower—Case managers partner with their clients to support the client's vision for change. Change is based on the client's wants, needs, and desires. It is not based on the future state the case manager envisions for the client but rather the health and wellness state that the client seeks to achieve for themselves. Case managers empower their clients with the knowledge and tools necessary to achieve the identified goals for change, but we cannot mandate change. We advance the client's ability to use his or her individual strengths and resources to achieve the goals of health behavioral change that the client has embraced.

TOOLS ASSOCIATED WITH MOTIVATIONAL INTERVIEWING

The Readiness Ruler—A self-evaluation tool to assess where an individual is at with respect to the importance, confidence, and readiness to make a change, on a scale of 1 (being not at all) to 10 (being 100 percent). It can also be used to evaluate the client's confidence in managing his or her health in the next environment of care.

Brief Medication Questionnaire—A tool for screening adherence and barriers to adherence. The tool includes a five-item Regimen Screen that asks clients how they took each medication in the past week, a two-item Belief Screen that asks about drug effects and bothersome features, and a two-item Recall Screen about potential difficulties remembering.

Patient Health Questionnaire (PHQ-9)—A multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression.

Maslow's Hierarchy of Needs

This theory was authored by Abraham Maslow in 1943 and is founded in the concept that people are essentially motivated to achieve certain needs with certain categories of need taking preference over others. Basic physical needs that are vital to survival are the foundation of this hierarchy, which is often presented as a pyramid. Other needs include psychological needs and self-fulfillment needs.

Maslow proposed that behavior is motivated by the need to fulfill basic needs and once one level of need is met, the person is motivated by the next level of need. Basic needs include physiological needs such as food, water, thermoregulation, rest, and oxygen as well as a need for safety including shelter and freedom from physical or emotional harm. Psychological needs include belongingness, meaningful relationships with others, and esteem needs such as prestige and a feeling of accomplishment. The final group of needs is self-fulfillment or self-actualization needs, which are considered to be the need to learn, to create, to understand, and to experience attainment of full self-potential.

In illness or injury, clients regress from higher levels to lower levels in order to focus on obtaining the basic needs that are essential to life. As case managers, we partner with other health care professionals and our clients/families/support systems to address wants and needs that are most commonly associated with meeting physiologic and safety needs.

BEHAVIORAL HEALTH CONCEPTS (E.G., DUAL DIAGNOSES, SUBSTANCE USE, ABUSE, AND ADDICTION)

Health care delivery in America previously presented two specific arenas for disease treatment and management—the physical and the psychological. These distinct categories of health compromise were rarely integrated, with one group of providers addressing the mechanics of the physical state and another group focusing on the emotional or mental health status of the client. Today, we see an integration of the physical and the psychological with multidisciplinary teams considering the biopsychosocial aspects of disease. This holistic view of both human behavior and the well-being of the body is often referred to as behavioral health.

Behavioral health is defined as a blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive care across the health care continuum. Behavioral health is commonly associated with substance abuse conditions, health behaviors that contribute to the development and exacerbation of chronic disease, life stressors and crises, serious psychological distress, and stress-related physical symptoms. The term may also refer to a health care system that addresses the diagnosis and treatment of mental health, substance abuse, and associated physical disorders with an integrated delivery of care provided by psychiatrists, primary care physicians, social workers, case managers, and other health care professionals.

Integrated behavioral health care delivery utilizes that diverse team of health care professionals to partner with clients and families while utilizing a systematic and cost-effective approach to provide client-centered care that emphasizes a broader approach in promoting both physical and emotional health. Processes that advance an integration of both physical and behavioral health are vital to health care delivery in America since diseases that compromise the behavioral health of the client touch more than 68 million Americans or 20 percent of the American population each year.

Common adult psychiatric disorders include anxiety disorders, bipolar disorder, eating disorders, major depressive disorders, obsessive-compulsive disorder, panic disorders, postpartum depression, personality disorder, PTSD, schizophrenia, substance abuse, dependence and misuse, and social anxiety phobia.

The U.S. Department of Health and Human Services has founded a department dedicated to addressing and advancing the behavioral health of the nation. This agency, the SAMHSA, is charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and the monetary cost to society resulting from substance abuse and mental illness. SAMHSA defines substance misuse as the use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute as misuse (e.g., underage drinking, injection drug use). SAMHSA also defines addiction as the most severe form of substance use disorder, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disorder that has the potential for both recurrence and recovery.

As case managers partner with clients who have been diagnosed with behavioral health disorders and seek to advance both the physical and behavioral health of the client, it is important to develop an understanding of accepted standardized criteria for the diagnosis and classification of psychiatric disorders.

The most accepted source for this criterion is the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), which is published and maintained by the American Psychiatric Association (APA). DSM-5 is an authoritative compilation of common definitions and criteria sets for classifying mental disorders. It assists clinicians in forming a consistent diagnosis of behavioral health disorders as well as establishing an accepted method of disease classification that is consistent across all environments of care including inpatient, partial hospitalization, outpatient, primary care, and specialty practices. DSM-5 presents three distinct categories: a diagnostic classification, diagnostic criteria sets, and a descriptive text. Each diagnosis has a specific description and detailed diagnostic criteria, which includes symptoms that must be present (and for how long) as well as a list of other symptoms, disorders, and conditions that must first be ruled out to qualify for a particular diagnosis. The final area of DSM-5 is a comprehensive descriptive text that offers information regarding prevalence, risk and prognostic factors, functional consequences of the specific diagnosis, culture and gender-related diagnostic issues, and differential diagnosis.

DSM-5 is organized in a sequence that reflects the developmental life span beginning with diagnoses typically identified in childhood followed by adolescence, adulthood, and later life. Neurodevelopmental disorders are also components of the revised classification criteria with a specific focus on autism, intellectual development disorders, attention deficit hyperactive disorder/, and tic disorders.

The classifications for behavioral health diagnoses detailed within DSM-5 were recently adapted by the *International Classification of Diseases*, Tenth Edition, Clinical Modification (ICD-10). According to the APA, these changes allow for the alignment of terminology utilized in DSM-5 with terms detailed within the mental health chapter of ICD-10. This includes the addition of several new codes to reflect diagnoses that were updated in DSM-5. The introduction of these new codes may advance improved accuracy in diagnostic recording and communication among clinicians as well as facilitating enhanced data collection.

In addition to disease classification, DSM-5 also incorporates a greater focus on cultural competency throughout the manual. Since different cultures verbalize or even exhibit symptoms in ways specific to that culture, it is important to be aware of the unique circumstances that may arise from the client's cultural, racial, ethic, spiritual, or geographic background.

CLIENT ACTIVATION, EMPOWERMENT, AND ENGAGEMENT

Clients who are actively involved and engaged in the care of their health and adhere to a client-centered treatment plan generally experience improved outcomes of care. To fully understand the concept of client engagement, it is necessary to understand not only the concept of client engagement but also the primary elements of engagement that include client empowerment, engagement, and activation.

Client empowerment is defined by the World Health Organization (WHO) as a "process through which people gain greater control over decisions and actions affecting their health and should be seen as both an individual and a community process". Client empowerment can also be defined as a "process in which clients understand their role, are given the knowledge and skills by their health care provider to perform a task with information offered in an environment that recognizes community and cultural differences and encourages client participation".

One definition of client engagement presented by the Agency for Healthcare Research and Quality is: the involvement in their own care by individuals (and others they designate to engage on their behalf), with the goal that they make competent, well-informed decisions about their health and health care and take actions to support those decisions. Client engagement is also defined as a concept that combines a client's knowledge, skills, ability, and willingness to manage his or her own health and care with interventions designed to increase activation and promote positive client behavior. Recently, the Center for Medicare and Medicaid Services (CMS) offered the following: "Patients and families are partners in defining, designing, participating in and assessing the care practices and systems that serve them to assure they are respectful of and responsive to individual patient preferences, needs, and values. This collaborative engagement allows patient values to guide all clinical decisions and drives genuine transformation in attitudes, behavior, and practice." CMS also states that client and family engagement are key factors in advancing health care quality and client safety.

The words *client engagement* and *client empowerment* should not be used interchangeably. Empowerment is a process that advances the client's ability to think critically and act autonomously. Engagement is an all-encompassing concept that refers to the client accepting an active role in addressing his or her health, illness, chronic disease, or injury.

Specific definitions of client empowerment are available from a number of sources and include the following:

- Client empowerment concepts assert that to be truly healthy, clients must bring about changes in their social situations and in the environment that influences their lives, not only in their personal behavior.
- Philosophy that clients are active participants in, not passive recipients of, the caring process, and thus should be well informed about all aspects of their health,

wellness status, and disease state, to gain maximum health benefit within the context of their social demands.
- The freedom to choose where and when one has treatment and also implies that clients should retain autonomy and responsibility for decision making throughout the course of their treatment.
- Empowerment requires an individual to take care of oneself and make choices about care from among the options identified by the health care delivery team.

Although many definitions of client empowerment are available, the concept of client empowerment generally includes the provision of information to the client in a manner that addresses the client's health literacy, linguistic abilities, cognitive status, and cultural beliefs with the goal of fostering informed decision making regarding treatment options and the client's unique ability and willingness to follow a plan to address illness or injury while moving to the highest level of wellness that is attainable.

Client empowerment provides a path for moving from a biomedical model of care in which compliance or client obedience to the plan of care was highlighted to a client-centered model in which a joint responsibility for achieving agreed-on outcomes is accepted and supported.

Client empowerment is the holy grail of care coordination. It is a meaningful concept that

- Supports the client's decision-making capabilities and rights
- Advances the identification of client-centered, meaningful, and achievable goals
- Facilitates access to information and resources
- Allows the client to make informed decisions rather than passively accepting the decision a health care professional makes
- Fosters critical thinking skills
- Enables the client to clearly state his or her preferences for care
- Promotes client understanding of the need to make necessary changes to his or her lifestyle in order to manage health
- Diminishes the client's feelings of abandonment or a lack of support during active treatment and subsequent health management processes
- Supports the client in taking responsibility for his or her heath and to actively seek care only when necessary
- Reminds the client that management of his or her health is a journey, not a destination.

It is important to remember that client empowerment and client accountability are both required to achieve desired client-centered outcomes.

The majority of client care is not delivered by health care professionals but rather provided by clients and their families/support systems and, generally, provided in the environment in which the client resides. Empowerment is supporting clients in each environment of care in order to gain control of their illness, injury, or disease state; to accept the clients' abilities and challenges; to meet the clients where they are at and to assist the clients to move forward from where they are to where they want to be.

Although the client is in control, it does not imply that the case manager or care coordinator is not able to support the client with information or services that will advance his or her knowledge regarding the illness or injury, the steps necessary to successfully treat that illness or injury, or the consequences of not following the path to wellness that was designed through shared decision making and the continuous support of his or her multidisciplinary treatment team.

One of the goals of the case manager/client partnership is strengthening the client's role in his or her own care. When the client is an empowered and active member of the transitional care and continuing care delivery teams, that client is better equipped to:

- Participate in shared decision making and gain better understanding of his or her rights, responsibilities, and ability to make informed choices
- Identify and implement appropriate solutions to closing gaps in or removing barriers to care
- Become curators of personal health information
- Overcome "white coat syndrome" by preparing questions prior to physician visits and confirming understanding of physician responses prior to leaving the visit
- Express confidence in his or her ability in the prescribed environment of care post transition from the acute care facility

When we see clients as empowered members of the team, our traditional "paternalistic" focus moves toward a collaborative, respectful, and team-based view of the client. As partners, we do not just inform clients but offer them new skills and tools that will advance self-management of their health.

Patient or client activation represents the knowledge, skills, willingness, and confidence a person has in managing his or her own health and health care. This is a key concept for the case manager as it assists in identifying clients who are less likely to play an active role in staying healthy or are less motivated to seek help when they need it to follow a continuing care plan or to manage their health when they are no longer receiving routine care.

Some may say clients are noncompliant when adherence to the treatment plan is compromised. According to the WHO, the preferred term for any gap in a client's ability to follow the treatment plan is nonadherence. The term *nonadherence* implies a shared accountability for both the client and the treatment team in identifying the steps necessary to advance client activation and to assist in moving the client toward a stronger role as an active member of the treatment team.

Client activation is a unique measure of engagement and empowerment that can be used to evaluate the effectiveness of interventions and to measure the performance of health care organizations in involving clients in their own care and supporting shared decision making across each aspect of transitional care.

As many as 40 percent of the American population have low levels of activation. These individuals tend to be passive, feel overwhelmed by the steps necessary to manage their own health, and may not understand their role in the care management process.

Additionally, they may:

- Feel overwhelmed with the task of managing their health
- Have little confidence in their ability to have a positive impact on their health
- Demonstrate limited problem-solving skills
- Offer a history of substantial experience of failing to manage their health that may have prompted multiple episodes of care
- Say that they would rather not think about their health, and are generally disposed to being passive recipients of care

Clients who are less activated experience:

- More frequent readmissions to acute care (within 30 days of discharge)
- More medical errors
- Poorer care coordination among health care providers
- A loss of confidence in the health care system

And, clients who are more activated have been found to be more engaged in:

- Preventive behaviors
- Healthy behaviors
- Information-seeking behaviors
- Self-management behaviors

A primary goal of the care coordination and case management process is assisting the client to have a safe, timely, efficient, and effective health care journey. One of the specialized skills, knowledge, and competencies professional case managers apply throughout the case management process in order to foster achievement of that goal is performing a comprehensive assessment of client activation, empowerment, and engagement.

Judith Hibbard, DrPH, of the University of Oregon has created a Patient Activation Measure. Although the comprehensive process associated with the detailing of specific levels of client activation requires a subscription, the concepts associated with measuring the client's level of activation are available to everyone.

A client who is disengaged and overwhelmed is said to be at Level One. These individuals tend to be passive and feel overwhelmed by managing their own health. They may not understand their role in the care process. Clients who demonstrate Level Two activation may lack the knowledge and confidence to manage their health.

Level One and Level Two clients generally:

- Have little confidence in their ability to have a positive impact on their health
- Misunderstand their role in the care process
- Have limited problem-solving skills
- Have had substantial experience of failing to manage their health, and have become passive in managing their health
- Say that they would rather not think about their health

Clients at Level Three appear to be taking action but may still lack the confidence and skill to support their behaviors. And, finally, Level Four clients have adopted many of the behaviors needed to support their health but may not be able to maintain them in the face of life stressors.

In delivering case management interventions that are respectful of the client's level of activation, it is important to meet the client at the specific level of activation unique to that client and to develop a case management plan that supports the current level of the client. Additionally, the case manager endeavors to partner with the client to develop a pathway for moving to a higher level of client engagement.

TERMS ASSOCIATED WITH CLIENT EMPOWERMENT, ENGAGEMENT, AND ACTIVATION

Self-advocacy: The practice of case management is founded on the principle that a balance of client advocacy and fiscal responsibility provides a significant benefit to the client, their community of care, health care delivery systems, and payer sources. The Philosophy of Case Management as presented by the CCMC states "Case management facilitates the achievement of client wellness and autonomy through advocacy, assessment, planning, communication, education, resource management, and service facilitation. Based on the needs and values of the client, and in collaboration with all service providers, the case manager links clients with appropriate providers and resources throughout the

continuum of health and human services and care settings, while ensuring that the care provided is safe, effective, client-centered, timely, efficient, and equitable. This approach achieves optimal value and desirable outcomes for all—the clients, their support systems, the providers and the payers."

Advocacy is a core component of the case management process that includes both advocating for our clients and supporting the client's ability to advocate for themselves. Self-advocacy is often defined as speaking up for or advancing your own self-interests. In health care, self-advocacy is defined as the client's ability to advance their unique goals, desires, and needs. This includes effectively communicating those goals, needs, rights, and, even, deficiencies to the health care team. Clients who advocate for themselves are active participants in their own care, ask questions regarding their health and the steps necessary to advance the achievement of desired goals. They communicate barriers to goal achievement and ask for assistance in identifying support groups and alternative funding resources. The case manager is viewed as a partner and a resource in their health care journey.

CLIENT EDUCATION/HEALTH EDUCATION

Advancing a client's understanding of their health, wellness, and/or disease state supports client engagement and empowers that client in seeking to become an active and vital member of the treatment team. Client education is defined as a specific process by which the client comes to comprehend his or her physical condition and self-care through the use of various tools and experiences. The primary goal of patient/client education is that the client will not only understand his or her current health status but also be able to make appropriate health care decisions and make changes as necessary to reach optimal health. Other definitions of client education include:

- A process of providing information to a client on his or her medical condition, treatment regimen, or processes in which he or she becomes involved with the health care team
- Information is based on the patient's level of understanding, existing knowledge, and feedback (comments, body language, or questions) he or she provides
- The process by which health professionals and others impart information to clients that will alter their health behaviors or improve their health status
- The process of informing a client about a health matter to secure informed consent, client cooperation, and an enhanced level of client adherence and persistency.

To be effective, client education must be delivered at a time both the educator and the client can be engaged in the process. Timeframes for the educational process must be scheduled to include adequate time for the delivery of information, the acceptance of that information, and appropriate time dedicated to answering questions the patient may have regarding all topics covered during that learning process.

Verbal education is supported by accompanying written information that is specific to the client's needs and provided in a manner the client can understand and assimilate. Multimedia presentations may be helpful based on the client's preference for learning. Other suggestions regarding the learning process include:

- Assess the client's current knowledge about his or her condition
- Make a plan with your client and his or her support person regarding the best time for delivering education and the preferred method of delivery—verbal, visual, multimedia

- Establish realistic learning objectives for each conversation
- Select resources that fit the client's needs
- Ask—Is there any other information that might be helpful to you

Some clients need time to adjust to new information, master new skills, or make short- or long-term lifestyle changes. Therefore, it is also suggested to schedule a follow-up interaction with the client to reinforce provided information and respond to any additional questions.

Education should be specific to each client with a focus on providing information that supports the client's health literacy, cultural beliefs, and preferred mode for learning.

CLIENT SELF-CARE MANAGEMENT (E.G., SELF-ADVOCACY, SELF-DIRECTED CARE, INFORMED DECISION MAKING, SHARED DECISION MAKING, AND HEALTH EDUCATION)

Self-care management can be defined as the decisions and behaviors that clients utilize to direct their health care, manage their illness, make informed decisions about care, and engage in healthy behaviors. As clients, their families and support systems seek to navigate the turbulent waters that are often representative of health care delivery, it is vital that they are prepared to participate in the necessary aspects of care that promote the attainment of each outcome the client seeks to achieve.

Many of the clients may not understand the information provided to them. Some may not actively participate in the broad array of factors that are necessary to successfully consider the options for health care management or the steps necessary to effectively and consistently execute the components of that care. Enabling clients to participate in decision making and to adhere to healthy behaviors requires a collaborative relationship with all members of the care delivery team including the case manager. This partnership supports clients in building the skills and confidence they need to lead active and fulfilling lives.

Informed decision making is a choice made by a client regarding his or her health, illness, or injury and the steps necessary to treat or manage his or her health or health compromise. This process includes obtaining and understanding relevant information, being provided an opportunity to have a meaningful discussion with a health care professional regarding that information, and considering whether provided information is sufficient to advance the decision-making process. Informed decisions are based on

- The client's capability to receive, understand, and process information provided by a health care professional in a manner that is transparent, well-balanced, and appropriate based on linguistic and health literacy of the client.
- An ability to make a voluntary determination that reflects the client's set of values and goals

Shared decision making is a process that advances collaboration between a client and his or her treatment team in order to determine the path to disease management. Each client-centered path for care is based on clinical evidence that balances the risks for care and expected outcomes of care with client-identified preferences and values. Shared decision making may foster greater client adherence to the treatment plan based on the client's concurrence with and understanding of the health care plan. Other benefits associated with shared decision making include reduced anxiety over the process of care, improved

health outcomes, reductions in unwarranted care and/or costs, and greater alignment of care with client values. An often forgotten benefit of shared decision making especially in situations in which there is no clearly superior path to treating or addressing a disease state is supporting the client's ability to choose a path that most closely aligns with that client's unique preference and values.

Models of chronic care management are often based on shared decision making with a focus on the client's role in managing his or her health conditions and implementing strategies to foster effective self-management across all transitions and providers of care. The chronic care model utilizes evidence-based clinical guidelines as the basis for shared decision making and promotes a culture of continuous improvement that is supported by clinical information systems and analytics.

Self-efficacy: Self-efficacy is defined as the extent to which people believe they are capable of performing specific behaviors in order to attain desired goals. Self-efficacy impacts an individual's emotions, cognition, behaviors, and motivation to initiate and sustain identified health care management activities.

COMMUNITY RESOURCES

Health care delivery includes a strong and significant focus on the biopsychosocial aspects of health, illness, or injury. Assessing the physical, emotional, and social aspects of care is a vital aspect of the case management process, and the deep interrelationship of these factors impacts the ability of the case manager to facilitate or advance the achievement of client-identified goals. Although the interface of physical and emotional health serves as the foundation for the development of a case management plan, the social determinants of health may be overlooked. The success or failure of case management interventions is often reliant on the ability of the case manager to realize the interplay among the client's biologic health, behavioral health, and social and cultural influences on health that may determine final outcomes achieved for and by the client.

Social Determinants of Health

The WHO defines social determinants of health as "the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world."

The U. S. Office of Disease Prevention and Health Promotion in *Healthy People 2020* presents a view of health as not just being formed by genetics and lifestyle decisions but also by "access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships."

Examples of social determinants include:

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services

- Quality of education and job training
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Residential segregation
- Language and literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Culture

It is important for each case manager to realize that the client's path to disease or health management also includes many of the factors associated with the social determinants of health. A component of each case management assessment is the identification of any factors impacting the client's ability to attain the goals he or she wishes to achieve.

When the client's ability to move toward goal attainment is compromised by economic instability, education, complex health care delivery systems, access to health care systems, or the environment in which the client lives, the case manager is charged with facilitating client awareness of and connections to community support and resources. This statement is supported by the CMSASOP, which also details the role functions of professional case management as "coordinating referrals to community-based support services and resources across health providers and care settings".

Knowledge of available community resources is integral to the practice of case management, and the term *resource* is included in the current definition of case management as offered by the CMSA. This definition states, "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."

Resources can include caregiver support, services that remove or mitigate barriers to obtaining care, financial assistance, educational resources that enhance the client's knowledge and assist the client to move toward self-advocacy, and linkage to cultural and linguistic resources that advance goal achievement.

Key resources that may be available to assist clients in their health care journey can include:

- Elder care services such as the Area Agencies on Aging (AAA), which includes more than 600 organizations throughout the United States that provide a variety of services for those over age 60. These organizations focus on services provided in a local area. Some of the services coordinated by the AAA may include:
  - Nutrition
  - Caregiver support

  - Referrals to assistance and support programs
  - Insurance counseling with a focus on Medicare
  - Hired, nonmedical transportation services
  - Assistance completing applications for some assistance programs such as Medicaid
- Fraternal and religious organization
- Pharmacy assistance programs are available from pharmaceutical organizations, retail pharmacies, and organizations dedicated to advancing the connection between pharmaceutical manufacturers and consumers. This final category includes RxAssist (rxassist.org), the Partnership for Prescription Assistance (ppaex.org), and NeedyMeds (needymeds.org). A low-income subsidy (LIS) or Extra Help may also be available for Medicare Part D beneficiaries with limited income and assets.
- Support for veterans is available from a number of organizations including the Veterans Administration and veteran-related organizations such as the Veterans of Foreign Wars, the American Legion, the Wounded Warrior Project, and the Vietnam Veterans of America. One source of information regarding veteran services is the Veteran Service Officer who is generally located within the county in which the client resides. In addition to assisting a veteran in applying for disability benefits, these knowledgeable individuals provide information, referrals, and resources on education, employment and business, and death benefits.

CONFLICT RESOLUTION STRATEGIES

Because case managers support our clients during times of illness and injury that may prompt emotional stress, conflicts might arise among families, caregivers, and even among the health care professionals that address the client's health issues. Conflict resolution is often a function of the case management professional.

The NASW SOP detail conflict resolution as a component of a case management practice. The NASW states the social work case manager's scope of practice might include activities such as "mediation and conflict resolution." The Code of Professional Conduct for Case Managers as offered by CCMC states, "Because case management exists in an environment that may look to it to solve or resolve various problems in the health care delivery and payor systems, case managers may often confront ethical dilemmas. Case managers must abide by the Code as well as by the professional code of ethics for their specific profession for guidance and support in the resolution of these conflicts."

Based not only on these two authoritative statements but also the basic case management mandate of patient advocacy, conflict resolution strategies are necessary components of each case manager's toolbox. Conflict resolution is defined as a dynamic process of resolving a dispute or disagreement. It mainly aims at reconciling opposing arguments in a manner that promotes and protects the human rights of all parties concerned.

Conflicts that arise often associated with the practice of case management include but are not limited to end-of-life issues, decisions associated with transitions of care or treatment pathways, financial matters, and determining who has control of the decision-making process.

Clients, their families, and caregivers as well as members of the health care delivery and/or support team may all respond to conflict or anticipated conflict in a unique manner. The five most common responses to conflict include avoidance, competition,

accommodation, compromise, and collaboration. Avoidance is the most overused conflict resolution technique employed by many health care professionals. It results in not addressing the conflict. Competition results in pursuing one's own goals at the expense of another (win–lose situation). This may be appropriate when a quick or unpopular decision has to be made. Accommodation results in meeting the goals of the other person (lose–win situation). This may be appropriate when the issue or goal is more important than winning, the other individual is more powerful, or when an individual is wrong. Compromise combines assertiveness and cooperation (lose–lose situation). This may be effective when individuals are of equal power and an expedient answer is needed. A match between the action and the nature of the conflict will most likely result in a resolution with desirable outcomes. Collaboration results in finding a mutual agreeable solution (win–win situation).

Collaboration is often the most desirable approach in resolving conflict and may include:

- A data-gathering stage to learn how each person who is engaged in conflict perceives the situation. It generally focuses on individual meetings held in a safe environment in order to hear how each person perceives the components of the conflict.
- Development of an agenda for discussing a list of issues that serve as the basis for the conflict.
- A meeting with all participants with a goal of increasing each person's understanding of all aspects of the conflict.
- The problem-solving stage in which all parties meet to explore options and consider solutions to the disrupted situation.

Other strategies for advancing problem solving and achieving conflict resolution include:

- When angry, separate yourself from the situation and take time to cool down.
- Attack the problem, not the person. Start with a compliment.
- Communicate your feelings assertively, not aggressively. Express them without blaming.

TERMS ASSOCIATED WITH CONFLICT RESOLUTION

Negotiation is a dialogue held between two or more people or parties to reach a beneficial outcome or solution. Negotiation is also defined as a process through which compromise or agreement is reached while avoiding argument and dispute. The parties engaged in a negotiation process control that process, form their own decisions, and reach agreement without the oversight of a third-party decision maker.

Mediation: Considered a voluntary process, mediation is directed by an impartial person or mediator who facilitates communication and promotes reconciliation among the parties in dispute in order to advance the identification of a mutually acceptable agreement. Mediation is considered to be an informal, flexible, and confidential process that seeks to reduce hostility and foster preservation of ongoing relationships.

Arbitration: Led by an impartial party or parties, arbitration is a formal type of dispute resolution in which the decision of the arbitrator or panel of arbitrators can be binding. More formal than mediation, the parties in dispute may present testimony and other substantiating documents to assist the arbitrator in forming an equitable resolution of the dispute.

- Focus on the issue, not your position about the issue.
- Accept and respect that individual opinions may differ, don't try to force compliance, work to develop a common agreement.
- Do not review the situation as a competition, where one has to win and one has to lose. Work toward a solution where both parties can have some of their needs met.

CRISIS INTERVENTION STAGES

Although the term *crisis* is often associated with any event that may lead to a difficult, unstable, or dangerous situation, it is most frequently defined in health care as a critical, decisive point in which conflict may reach high tension, cause distress, or prompt functional impairment. The cause of the crisis may be a stressful or traumatic event, an exacerbation of a disease or a situation perceived as an underlying disruption of normalcy.

Crisis intervention is considered to be immediate and short-term care aimed at assisting individuals in a crisis to move toward improved biopsychosocial functioning and to minimize the potential for long-term psychological trauma. While many models for crisis intervention exist, the key elements of the intervention process include:

- Conducting a comprehensive assessment to identify the biopsychosocial aspects of not only the crisis but also the response of the client and family to that crisis. The assessment should be unbiased and nonjudgmental and include a focus on client safety. As with any comprehensive assessment performed by a case manager, open-ended questions are utilized to allow the client to fully detail the physical, emotional, and psychological aspects of the crisis.
- Referred to as "validation and ventilation," clients are provided a safe environment to express and discuss aspects of the crisis. This allows those who are in crisis to detail their perspective of the crisis and consider steps they may be prepared to take in order to manage or control the crisis.
- Assist the client to develop a crisis management plan that reflects the client's goal for managing the crisis as well as connecting the client to community or support services that will assist the client to achieve the identified crisis management goals. The crisis management plan generally includes specific steps to avoid or mitigate any precipitating factors that might prompt the development of another similar crisis.
- Finally, the crisis management plan is put into action. The results of the plan are evaluated and necessary follow-up is provided.

It is important to note that disaster management and crisis intervention are two unique processes. In the first, the client is saved. In crisis intervention, support and tools are offered to advance the client's ability to save themselves.

HEALTH COACHING

Health coaching is defined as a collaborative process of self-discovery, support, inspiration, and confidence building. It motivates clients to use information for realistic goal setting, to identify their motivations to change, and to develop and maintain personalized strategies based on individual strengths. Health coaching is not the delivery of information

but rather a clinical communication style that actively engages the client in affecting health behavioral change.

The goals for the health coaching process are collaborative and seek to promote client empowerment and increase self-efficacy and autonomy while enabling self-management especially in chronic states. Health coaching also seeks to enhance the well-being of the individual and advance the attainment of client-centered goals.

Health coaching may be more successful when provided in face-to-face meetings or telephone calls. The time, date, and goals for each contact should be mutually agreed on. At the beginning of the session, the client should always confirm that the time is still okay before proceeding.

Health coaching is not didactic but rather a process in which the case manager accepts a role of listener, assessor, and partner in a journey that may bring the client closer to the desired goal achievement. The assessment process includes encouraging the client to present the issues that concern him or her most significantly. This will convey to the client that the coach is listening, will foster a sense of control, and will put the client at ease. The case manager can use the client's stated concerns as a starting place and subsequently guide the conversation to reflect the case manager's primary concerns for the client.

To be effective as a health coach, case managers seek to connect the coaching topic to the client's life goals and values by focusing on the client as a person, not a specific diagnosis or behavior. Each health coaching intervention focuses on advancing client self-management and satisfaction, and promoting improved outcomes of care.

The role of the case manager is not to "fix" the client but rather support the client's ability to move toward the goals the client wishes to achieve. Case managers cannot expect their clients to want a healthier behavior based on the sole concept that every client should want to be healthier. Case managers are charged with seeking to understand what motivates their clients. This can only be achieved by listening to the client. Sometimes clients do not know what truly motivates them or that demonstrated behaviors are not in sync with their values. An open discussion can assist the client to realize these discrepancies and guide him or her toward appropriate health behavioral changes that foster the achievement of identified health goals. Health coaching consistently advances client education, supports health behavioral change, and motivates the client to achieve improved states of disease management, health, or wellness.

COMMUNICATION (E.G., INTERPERSONAL, GROUP DYNAMICS, RELATIONSHIP BUILDING)

The broad topic of communication includes interviewing techniques and interpersonal communication including group dynamics and relationship building.

Communication is defined as the sending and receiving of information. It can be verbal or nonverbal, and to be effective it must be bidirectional. Bidirectional communication is composed of two connected parties or devices that can communicate with one another—to and from the receiver and to and from the sender. Avenues for effective communication can be variable. Forms of communication include:

- Person to person with communication partners actively engaged in the conversation
- Written or digital methods of communication such as cloud-based sharing of information or utilizing tools that provide data-driven analytics

- Visual communication such as observing the patient or environment of care as well as nonverbal cues the patient offers. Kinetics is a nonverbal communication pattern that includes the use of stance, gestures, eye behavior, and other posturing by an individual to convey a message.
- Auditory forms of communication that extend beyond exchanged words such as prolonged pauses during discussions or the sounds of sighs or background noise during a phone conversation

The Centers for Disease Control and Prevention defines health communication as "the use of communication strategies to inform and influence individual decisions that enhance health." Communication also can be defined as the ability to share information with people and to understand what information and emotions are being conveyed to others. It is the art of imparting information and a means for connecting members of a team so that a common message is shared consistently.

Simply, communication is imparting information to the right person, at the right time, in an appropriate format or method and accepting information as presented without prejudice or misinterpretation. In health care, communication is a method for affecting change through listening, learning, assessing, informing, educating, and negotiating.

Using more than just words, effective communication encompasses a set of skills including nonverbal communication, engaged listening, managing stress in the moment, the ability to communicate at a level the communication partner understands, and the capacity to recognize and understand your own emotions and those of the person who is the receiver of the provided information.

Effective communication is the glue that helps you deepen your connections to others in order to improve teamwork, informed decision making, and problem solving. It enables you to communicate even negative or difficult messages without creating conflict or destroying trust.

Often, what we try to communicate gets lost in translation despite our best intentions. We say one thing, the other person hears something else, and misunderstandings, frustration, and conflicts ensue. Fortunately, the enhancement of communication skills might enable the case manager to even more effectively connect with others, build trust and respect, and feel heard and understood.

According to *Health People 2020*, effective and efficient health communication is seen to have relevance for virtually every aspect of health and well-being, including disease prevention, health promotion, and quality of life. With 8 percent of Medicare beneficiaries having limited English proficiency and approximately 19 percent of the American population having a disability that may include hearing, visual, and cognitive impairments, an essential element of the case management process includes facilitating the smooth flow of information from a sender to a receiver. It is not sufficient to ask the patient/family/support system if they understand specific information, but rather a case manager could seek confirmation of the specific details of that information transfer.

Research indicates that there are strong positive relationships between a case manager's communication skills and a client's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies conducted during the past three decades show that the clinician's ability to explain, listen, and empathize can have a profound effect on biological and functional

health outcomes as well as patient satisfaction and experience of care. Effective and efficient communication processes contribute to:

- Facilitating a comprehensive assessment—A bidirectional transfer of accurate and timely information is the foundation of every case management plan. When the validity of information gained during the assessment process is compromised, the efficacy of care coordination functions and actions may be in jeopardy. A case management plan that is built on an inaccurate understanding of client wants and needs is doomed to failure.
- Supporting shared decision making—Communication processes that engage the client, family, and various support systems facilitate effective information sharing regarding treatment and continuing care options. Effective communication also advances shared decision making by assuring that the client's unique values, preferences, and needs are considered and respected during each health care interaction and intervention.
- Improving the desired outcome of client education—Effective communication is supported by asking open-ended questions and using active listening skills to hear and interpret the information offered by the client. This promotes the timely development of a client-centered educational plan that supports the client's chosen path to disease, illness, or injury management.
- Advancing patient adherence and persistency—Effective, patient-centered communication is highly correlated with better patient adherence when based on the patient's understanding of their diagnosis, treatment plan, and the value of following that plan. If the case manager does not identify gaps or potential gaps in client knowledge and takes steps to close those gaps by working in collaboration with the client and the transitional care team, the client may be more likely to develop an adverse outcome that might prompt a potentially avoidable rehospitalization.
- Reducing client/family stress—A communication process that supports the continuing care plan while educating, engaging, and empowering the client and family to self-advocacy noticeably reduces stress for all members of the multidisciplinary team. Increased stress is often a by-product of trying to navigate the multiple components of a complex transitional plan that includes numerous steps to achieve identified client-centered outcomes.
- Facilitating timely interaction among all members of the care coordination team—A smooth handover of information from one provider of care to another is a required element of every transition of care. Without specific communication processes and pathways in place, the ability to advance positive health outcomes may be compromised.

While care coordination may be the basis for a practice of case management, it is the communication process that is the underlying foundation of care coordination. Case managers cannot coordinate care without efficient and effective communication with all members of the transitional care team including the patient/family/support system.

Group dynamics are the interactions, processes, attitudes, and behaviors that group members display. These dynamics impact each group member individually and the group as a whole. One member of the group may be the primary source of influence on the group especially when they are assertive in their opinions, take leadership of the group, or are seen as being authoritarian or charismatic.

Understanding the dynamics of the client's continuing care team including family and support systems and the health care delivery team that seeks to partner with them is a key function of the case management process. Does one member of the group contribute to dysfunction or monopolize every conversation? Is the group more successful in forming decisions when one member of the group is not available? Does one group member advance informed decision making more than others? These are observations that the case manager can make to assist in advancing consensus among members of the client's support team.

END-OF-LIFE ISSUES (E.G., HOSPICE, PALLIATIVE CARE, WITHDRAWAL OF CARE)

While each client's health state is unique with a level of wellness that can wax and wane, there is one truth that exists, life is linear. The days each of us experience flow from birth to death, with the majority of health care interventions occurring in the final years of our lives.

According to Medicare data, average Medicare per capita spending on traditional Medicare services for beneficiaries who died in 2014 was $34,529. That is approximately four times higher than spending for survivors and more than three times higher than the average among all beneficiaries in traditional Medicare. Approximately one-half of those expenditures were associated with inpatient costs, with only 10 percent of benefit dollars covering hospice or home health services during the final year of life.

Although the majority of adults indicate a desire to receive end-of-life care in the home environment, less than one-third of Medicare beneficiaries actually died in their home environment. The fact that death in an acute care or other formalized health care environment occurs more frequently than a death in the home environment may be reflective of the lack of end-of-life discussions among clients, their families, and the health care delivery team. End-of-life discussions between clients and their physicians may never transcend the broad topic of resuscitation or the identification of a health care agent.

In 2016, Medicare began covering advance care planning as a separate and billable service. Advanced care planning discussions are conversations that physicians and other health professionals have with their patients regarding end-of-life care and patient preferences. These discussions may include a broad array of concerns that seek to identify end-of-life goals including meeting physical needs such as pain management, nutrition, and hydration as well as other topics that are concordant with the client's values and wishes.

Advanced care planning is an ongoing process in which patients, their families, and their health care providers reflect on the client's knowledge, fears, hopes, goals, values, beliefs, and preferences to develop a plan that details choices for the delivery of health care interventions if that client experiences a diminished health state or incapacity to verbalize direction regarding the focus for care or treatment options. Often associated with aging, advanced care planning does not solely represent end-of-life decisions but rather addresses any significant threat to health that might require informed decision making when the client demonstrates a diminished capacity to do so.

Advanced directives, as defined by the CCMC, are "legally executed documents that explain the client's health care–related wishes and decisions". Completed by a client who has full decisional capacity, an advanced directive provides specific information regarding

the client's wishes for treatment or the identity of a surrogate decision maker should the patient's ability to make informed decisions be compromised.

Durable power of attorney for health care or health care proxy and a living will are two documents that serve to validate a client's wishes regarding how treatment decisions can be made if that client lacks decisional capacity. Durable power of attorney for health care is a legal document in which the client designates an agent to make health care decisions if that patient is temporarily or permanently unable to make informed decisions regarding their care. A living will is a legal document that summarizes a client's preference for future health care services or interventions. Commonly utilized to address resuscitation and life support, a living will may also specifically address client-specific preferences regarding pain management, transfusion of blood products, enteral feeding, dialysis, or other life-sustaining or maintaining procedures. Another document that combines both the components of a living will and a durable power of attorney for health care is known as Five Wishes. This document addresses personal, emotional, and spiritual needs as well as medical wishes. The "wishes" detailed within the document include health care proxy or agent, care the client wishes or does not wish to occur, level of comfort desired, wishes for how the client wants to be treated by people, and the wish for emotions and thoughts with their loved ones. The Five Wishes document is not accepted as an alternative for a durable power of attorney for health care or a living will in all states, and, therefore, the case manager should seek confirmation that the document meets the statutory requirements of the state in which the client resides or the state in which care is being delivered. It should be noted that any advance directive may be revoked orally by the client at any time as long as that client exhibits appropriate decisional capacity.

A coordinated effort across transitional services including paramedics, acute care facilities, and post acute environments of care with a goal of recognizing and adhering to client wishes regarding life-sustaining care can be facilitated through the utilization of a Physician Order for Life-Sustaining Treatment Form. Also referred to as Medical Orders for Life-Sustaining Treatment, Medical Orders for Scope of Treatment, or Physician Orders for Scope of Treatment, these documents clearly delineate the specific care that should be administered or withheld for a specific client at a specific time as directed by the physician. These documented physician orders are considered "portable" in the states in which this form of care coordination is recognized. Because these directives reflect client wishes for emergent care and are recognized across potential care settings, the possibility of unwanted resuscitation or hospitalization is diminished.

TOPICS ASSOCIATED WITH END-OF-LIFE

Withdrawal of care or the withdrawal of life-sustaining treatment involves a conscious decision to stop or remove care after it has begun. Clients with the capacity to make an informed decision have a right to either refuse care or life-sustaining treatment or to have treatment withdrawn as they desire. Although the courts generally have not differentiated between withholding and withdrawing care, ethical considerations appear to be more common with the withdrawal of care. In cases in which the client does not exhibit decisional capacity, may not be able to verbalize their wishes, or a health care proxy is not recognized, courts have sought clear and convincing evidence of a client's wishes before care can be withdrawn. In cases in which the client is refusing care, it is important to remember that the refusal of one form of care does not necessarily indicate a refusal of all care.

Hospice is defined by the CCMC as "a system of inpatient and outpatient care, which is supportive and palliative family-centered care, designed to assist the individual with terminal illness to be comfortable and maintain a satisfactory lifestyle through the end of life". The National Hospice and Palliative Care Organization expands on that definition stating that hospice is a "model for quality and compassionate care offered to people facing a life-limiting illness or injury that includes a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the individual's needs and wishes". Hospice also provides the support necessary for a client to die with dignity.

Palliative care is defined by the WHO as an approach that "improves the quality of life of patients and their families facing the problems associated with life-threatening illness", through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. Palliative care is often referred to as comfort care, supportive care, or management of symptoms. Similar to hospice, palliative care addresses the physical, intellectual, emotional, social, and spiritual needs of patients and their families. While hospice is generally provided to those patients with a life expectancy of less than six months or one year, palliative care is offered to clients with chronic or life-threatening diseases from the time of diagnosis throughout the course of treatment. Although the identified goals of palliative care are always specific to the individual served, the overarching goals for the delivery of palliative care include advancing quality of life by anticipating, preventing, and managing physical and emotional pain.

FAMILY DYNAMICS

Very few patients have a health care experience without a family or a support system accompanying them on that journey. Experienced case managers understand they partner with both the client and that client's family or support system. The importance of connecting with both the client and his or her family is represented within the CMSASOP, which state: "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." The Standards also describe a case management role that advances constant contact and collaboration with the client, the client's family, and the client's caregiver.

CMS has presented a number of quality strategy goals that advance "Better Care. Healthier People. Healthier Communities. Smarter Spending." One of these goals is related to strengthening person and family engagement as partners in their care ensuring that all care delivery incorporates the person's and caregiver's values and preferences while improving the experience of care and promoting self-management.

Because the client does not usually stand alone, it is vital to understand the family and support systems that surround the client. A system is defined as a set of connecting things or parts that form a whole. The systems that support a patient include, family, friends, caregivers, colleagues, neighbors, and other members of the client's community of care. As clients navigate the health care delivery system and make informed decisions regarding continuing care or transitional care services, these familial and related support systems may join together to form the primary pathway for informed decision making or, at the least, strongly influence the decisions made by the client. Because of the web

of support that often surrounds the clients, it is important for each case manager to understand the composition, functions, and abilities associated with family, caregivers, and other support systems throughout the client's episode of care.

Adaptive and Maladaptive Families

Family dynamics represents the interaction that exists among family members and includes family history, culture, and beliefs. Each family is unique in their ability to support the client in times of crisis or through the continuum of chronic disease management. Some families are remarkably adaptable in these crisis situations. They realize their individual and collective roles in advancing client-desired goals. Concepts associated with families that are adaptive and generally supportive of the client include:

- Flexible family roles: Adaptive families understand the family member that is ill may not be able to perform activities of daily living independently and that disease or injury may prompt the need for greater family engagement in the care of that member of the family. They may be required to accept the role of caregiver including such activities as medication management, scheduling and attending physician or other outpatient appointments, and delivering interventions such as changing dressings. Adaptive families may seek to share the caregiving roles equally so as not to overburden one family member.
- Problem solving: Adaptive families are not passive. They do not wait for someone to tell them what to do to solve the challenges that an ill family member creates. They seek to identify concerns and seek internal or external resources to solve them.
- Communication: When a family is able to openly discuss the problems they have identified, such as fears, unequal or unsustainable work burdens, or financial needs, they are able to share more caregiving tasks and implement solutions to identified challenges.
- Seek and accept help: Families may come to realize the problems encountered cannot be handled with the resources within the family. Adaptive families put aside reticence and a misplaced sense of pride and actively seek help from their community support network, charities, support organizations, or paid professionals. When help is offered, they accept it and incorporate it into their care plan.
- Community relationships: Both the client and their family can become isolated from the community due to the demands of caregiving or from grief or fatigue. The adaptive family realizes their community can be a source of physical, emotional, and financial support.

Families that are not participatory in client care, not supportive in planning for transitional care, or unable to agree to a proposed plan of care may be considered maladaptive. Maladaptive families are typically unable to achieve a balance between meeting a client's needs and maintaining their own ability to function. These families are often considered to be inflexible, disengaged, chaotic, and unable to effectively communicate with each other. These families may overindulge the client and foster dependency. In caring for the sick family member, maladaptive families may ignore or mistreat other family members. Conversely, maladaptive families may abandon or ignore the client. They may deny the existence of the client's illness or disability to the client's detriment. One family member may be charged with providing all care to the client with no support of other members of the family unit.

Dysfunctional families are generally considered families that experience conflict, misbehavior, or even abuse on the part of individual members of the family that occurs continually and regularly, leading other members to accommodate such actions. Children sometimes grow up in such families with the understanding that such an arrangement is normal. Dysfunctional families are primarily a result of codependent adults, and may also be affected by the alcoholism, substance abuse or misuse, untreated mental illnesses/defects or personality disorders, or family members emulating their own dysfunctional family experiences.

In partnering with clients and their support systems, case managers may wish to minimally assess

- A typical day in the home
- Identity of the primary decision manager
- Impact of illness on the family
- How other family crises have been dealt with in the past
- The family's understanding about the disease, treatment plan, and prognosis

Whether the family is adaptive, maladaptive, or dysfunctional, relating well with the family and understanding the stressful conditions that illness or injury can cause is an essential aspect of the case management process.

HEALTH LITERACY ASSESSMENT

Title V of the Patient Protection and Affordable Care Act of 2010 defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. In today's health care environment, the focus has moved from a system that focuses on the delivery of care to a value and quality-based structure for care and reimbursement that is patient-centered.

WHO has defined health literacy as "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health". Additionally, the American Medical Association defines health literacy as "a constellation of skills, including the ability to perform basic reading and numerical tasks required to function in a health care environment." Health literacy can also be defined as the ability to read, understand, and effectively use basic medical instructions and information. Diminished health literacy can impact the client's ability to understand instructions including those on prescription vials, appointment slips, medical education brochures, doctor's directions, and consent forms, and the ability to negotiate complex health care systems.

Addressing health literacy is not solely related to the skills of individual clients and their families. It is a dynamic process that is closely related to the skills of those who provide information to the client/family. A health care provider's or health care advocate's ability to use common words and to perceive whether a client is understanding a discussion or not is essential to all care coordination and communication processes.

Types of literacy include:

- Visual—able to understand graphs or other visual information
- Computer—able to operate a computer
- Information—able to obtain and apply relevant information
- Numeracy—able to calculate or reason numerically
- Oral—able to articulate and process verbally

Common causes of low health literacy are:

- Lack of educational opportunity
- Learning disabilities
- Cognitive deficits
- Use it or lose it—reading abilities lower with aging

True health literacy is only achieved when the information and services needed for addressing improved health are aligned with the skills and abilities of those needing them.

Teach-Back

Teach-back is a research-based health literacy intervention that improves communication and facilitates the achievement of client-centered and desired health outcomes. It might also be considered to be a method of evaluating a health care professional's ability to explain a specific set of instructions in a manner the client or caregiver is able to understand and retain. It is not a test of either the client's or the professional's ability to communicate and understand information but rather a method for confirming the successful transfer of information. In no way should teach-back ever be considered a test of the client's knowledge or ability to learn.

Teach-back is a technique utilized to assess client understanding of a topic by asking them to explain, in their own words or way, what they need to know or do about their health. It serves to confirm that information presented to the client/family/support system has been understood and that the client can perform the task or adhere to the information based on that explanation.

Teach-back is a cyclic process that begins with a client-appropriate discussion of the topic or procedure to be learned (**Figure 3-1**). To confirm client understanding of the

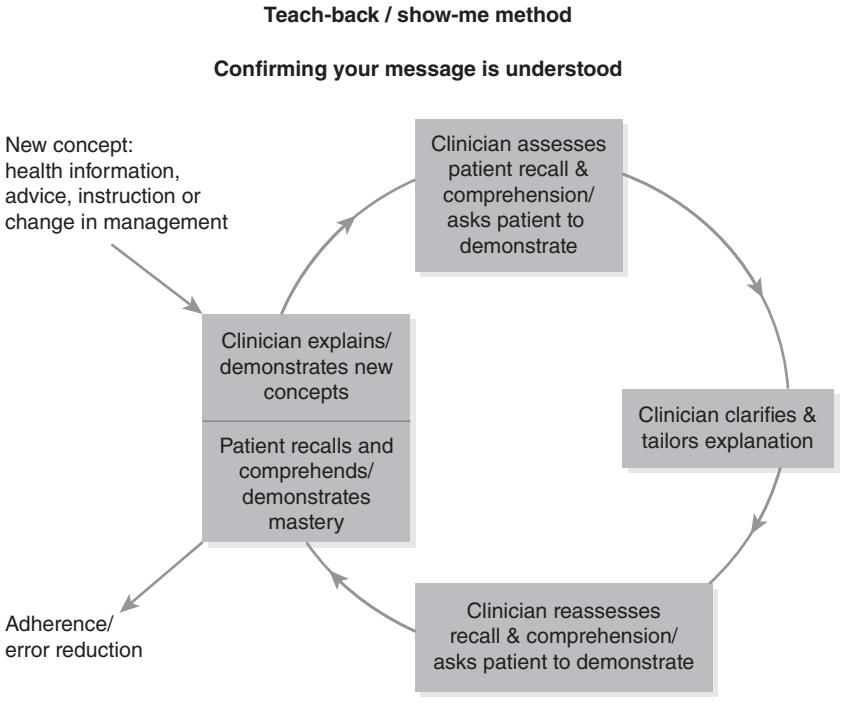

FIGURE 3-1 Teach-Back/Show-Me Method: Confirming Your Message Is Understood

Reproduced from HRSA. (n.d.). Effective Communication tools for healthcare professionals: Addressing health literacy, cultural competency, and limited English proficiency. Retrieved from https://pilot.train.hrsa.gov/uhc/pdf/module_02_job_aid_teach_back_method.pdf

information presented, the client is asked to "teach-back" the provided information. An example of a statement that might facilitate that assessment is "We covered a lot of information today and I want to make sure I explained things clearly. If you were trying to explain to your spouse the three medications you will be taking when you leave the hospital, what would you say?" The next step in the teach-back process is carefully listening to the information offered by the client and correcting any information that might have been misunderstood or inaccurately presented by the client. Information offered and assessed during the teach-back process may be either verbal or demonstrated.

Teach-back is a valuable tool as the outcomes associated with the effective use of teach-back might include:

- Improvement in patient understanding and adherence
- Decreased missed appointments
- Improved patient satisfaction and health care outcomes
- Increased patient trust in health care professionals
- Decreased readmission rates

The effective use of teach-back assists in identifying client-specific barriers to communication including low health literacy, hearing impairments, limited proficiency in English, and cognitive impairment.

It should be noted that in addition to teach-back being considered by the National Quality Forum as one of the 50 essential safe practices for improving in America, teach-back is also considered to be an "always event." Always events are elements of a client/family experience that should always occur when the client interacts with health care professionals.

MULTICULTURAL, SPIRITUAL, AND RELIGIOUS FACTORS THAT MAY AFFECT THE CLIENT'S HEALTH STATUS

Each client we meet is unique with life histories and influences that formed their lives, beliefs, and preferences for care. This cluster of knowledge and attitudes is cumulatively considered to be the client's culture. The CCMC defines culture as "the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups." Culture as defined by the National Transitions of Care Coalition is an "integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group."

No matter the definition, each client's culture as well as the cultural beliefs of his or her family and support system impacts the client's ability to successfully navigate health care systems and be fully engaged in management of his or her illness or injury. The significance of the case manager's role in understanding the importance of cultural awareness is detailed within the SOP (Standards) as presented by the CMSA. These Standards list relevant and meaningful concepts that guide a case management practice. One of those principles is the utilization of a "client-centric, collaborative partnership approach that is responsive to the individual client's culture, preferences, needs, and values."

Cultural competency, as defined by the CMSA, is most closely associated with "the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each."

The U.S. Department of Health and Human Services has recognized the importance of cultural awareness associated with the delivery of health care services and has developed a set of action steps intended to advance health equity, improve health care quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

These National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) are "based on the provision of effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." Available at www.thinkculturalhealth.hhs.gov, the CLAS Standards advance

- A culturally diverse governance, leadership, and workforce in all health care arenas
- Translation assistance to clients with limited English proficiency with educational materials in the preferred language of the client and caregivers
- The establishment of culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Each case manager is also accountable and responsible for maintaining a primary and consistent focus on the provision of client-centered and culturally relevant care. The CMSA Standards state case managers should

- "Practice cultural and linguistic sensitivity, and maintain current knowledge of diverse populations within their practice demographics"
- "Promote client self-advocacy, independence, and self-determination, and the provision of client-centered and culturally appropriate care"
- "Complete a thorough individualized client-centered assessment that takes into account the unique cultural and linguistic needs of that client including the client's family or family caregiver as appropriate"
- View all clients as "unique individuals and engage them without regard to gender identity, race or ethnicity, and practice, religious, other cultural preferences, or socioeconomic status"

To meet these Standards, the case manager must be aware of the cultural determinants that often impact the client's view of health and health care delivery. These cultural determinants include but are not limited to race, ethnicity, national origin, and migration background; geographic or regional culture or mores; sex, gender, gender identity, or gender expression; sexual orientation and marital or partner status; age and socioeconomic class; religious and political belief or affiliation; and physical, mental, or cognitive disability. An awareness of the client's culture and associated beliefs and values as well as how those beliefs and values are incorporated into the client's daily life and impact the client's health care journey is integral to the success of the continuing care plan across each care setting and throughout each episode of care.

Since culture is often a predominant force in shaping actions, behaviors, and values as the client moves through the health care continuum, it is important that the case manager consider the health beliefs that impact the client's understanding of what causes illness, how it can be cured or treated, and who should be involved in the process. Some cultures believe that illness is caused by a demon, evil spirit, or evil eye or curse. They may not accept a biomedical cause for illness and feel that no treatment based on Western medicine will change the course of the disease.

Cultural and religious beliefs can impact a client's health care experiences and outcome in many ways. Some of these include:

- How health care information is received
- What is considered to be a health problem
- How illness and disability are perceived
- How rights and protections are exercised
- How symptoms and concerns about the problem are expressed
- Who should provide treatment for the problem
- What type of treatment should be given or can be accepted
- The role of autonomy in decision making

The impact cultural beliefs have on a client's perspective of disease and treatment vary from culture to culture and sometimes from geographic region to geographic region. The following are a few examples of the impact culture may have on health and health decision-making processes:

- Asian heritage—May be reluctant to ask questions of authority figures such as physicians. Case managers might wish to encourage the client and/or family to ask questions or use teach-back as a technique to evaluate the understanding of the diagnosis and the continuing care plan.
- Hispanic heritage—Inquire about what personal health treatments they may use (folk medicine). May also consult a folk healer, known as a curandero. The case manager may also wish to inquire about food choices. Latino patients may believe in hot and cold food items to treat disease.
- Russian heritage—In Russia, bad news is not consistently provided to patients. Patients may demand to hear the truth, but they do not want to hear the bad news. The health care delivery team may wish to speak with the client and family to identify client preferences. The client and his or her family may also be distrustful of doctors. The client may not adhere to the prescribed treatment plan including not taking medications as prescribed or combining them with folk remedies.
- Native American heritage—May believe that when and where something happens is when and where it should happen. This can make keeping appointments of any nature quite difficult. The patient may have an appointment for 1 p.m. today and arrive three days later at 10 a.m. They arrive when "it should be."
- Pacific Island heritage—The extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honor of the family are more important than those of individual family members.
- Muslim patients—Many medications have a gelatin base. This pork derivative is taboo in Muslim culture, so alternative formulations or remedies are preferred. It is important to read nonverbal cues. Some members of the Muslim religion or culture may not be comfortable shaking hands with a member of the opposite sex. But if the patient extends his or her hand when you meet, of course you should shake it. Modesty is very important to Muslims, and many of them will prefer a same-sex provider, and will be uncomfortable undressing or may uncover only the part of the body currently being examined.

Advancing the provision of a culture-appropriate case management plan includes:

- Providing information in a manner that addresses both the client's health literacy and culture—use of an interpreter line is preferable to using a family member as an interpreter.

- Considering the use of validated tools to assess health literacy.
- Providing educational materials in the client's requested language.
- Using charts, graphics, and pictures to highlight educational strategies as well as using teach-back to validate effectiveness of educational processes.
- Building an educational plan that is client-specific and respectful of the client's culture and degree of health literacy—one size does not fit all.
- Following up with the client in a timely manner to evaluate the client's ability to apply and find value in provided education.
- Affirming client dignity and respecting cultural, religious, socioeconomic, and sexual diversity.
- Assessing cultural values and beliefs, including perceptions of illness, disability, and death.
- Understanding traditions and values of client groups as they relate to health care and decision making.

In addition to considering the client's cultural beliefs, each case manager is charged with considering how their own individual beliefs and values may impact their ability to provide culturally appropriate case management interventions. According to the U.S. Department of Health and Human Services, the ability to provide safe, timely, efficient, effective, and equitable health care services including case management interventions may be compromised by ethnocentrism, essentialism, and power differences. Ethnocentrism is defined as the tendency to believe that one's ethnic or cultural group is superior to all others, and that every other cultural or ethnic group is measured in relation to one's own. The ethnocentric individual judges other cultures or groups relative to his or her own particular ethnic group or culture, especially concerning language, behavior, customs, and religion.

Essentialism is a belief that all members of a specific culture have the same characteristics and beliefs, which are consistently different than those of the culture of the majority. This belief may reinforce stereotypes and inhibit the case manager from recognizing the unique nature of the individual being treated. Power differences are represented by the power imbalances that often exist in a patient–provider relationship. The health care professional may not realize the client's ability to advance informed decisions, to understand aspects of his or her disease, or to follow the steps detailed within a continuing health care plan. If this imbalance is not corrected, health care disparities are perpetuated and the client may never become fully engaged and empowered in becoming an active participant in developing and implementing a health care management plan.

PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT

The balance that exists between physical and psychological or behavioral health is delicate. If symptoms arise that are typically associated with a behavioral health state, a comprehensive medical evaluation should be performed in concert with psychological testing to rule out any underlying medical condition that may contribute to the development of those symptoms. Common medical conditions that might prompt behavioral symptoms include but are not limited to traumatic brain injury, thyroid dysfunction, hepatic compromise, forms of epilepsy, lupus, Lyme disease, heavy metal poisoning, cerebral tumors, memory impairment disorders, Parkinson's disease, and sexually transmitted diseases. If a physiological cause has been ruled out, a comprehensive psychological assessment is

necessary and appropriate. Comprehensive testing may use "self-report questionnaires." These questionnaires are standardized, validated tools that clients fill out by themselves. The Minnesota Multiphasic Personality Inventory and cognitive and intellectual problem solving, such as the Wechsler Intelligence Scales, are common types of these tools. This type of psychological assessment is different from an assessment derived from an interview with a mental health professional in that the self-administered examination provides a distinct type of data and allows flexibility in the timing and geography of its administration.

Other examples of validated assessment tools that represent both self-reporting tests and those administered by health care professionals include:

- Sentence completion test—A self-administered assessment that includes the first words of a sentence or stem and instructs the person being evaluated to complete the sentence with the first thought that comes to mind. Responses provide an indication of the client's attitudes, beliefs, motivations, and concerns.
- Patient Depression Questionnaire (PHQ-9)—A self-administered assessment that detects depression and the severity of any depression that may be present. A shortened version containing only two questions is the PHQ-2. This tool seeks to confirm the presence of depression but does not establish the severity of any identified depression.
- Mood Disorder Questionnaire (MDQ)—Another self-administered screening tool that may contribute to developing a timely and accurate diagnosis of bipolar disorder.
- Generalized Anxiety Disorder Scale (GAD-7)—This self-administered assessment is a validated screening tool for generalized anxiety disorder.
- The Million Behavioral Health Inventory (MBHI)—A 150-item self-reported assessment of psychosocial factors that may support or interfere with a chronically ill patient's course of medical treatment. It may be useful in assessing patients with chronic pain.
- Clock drawing test—Administered by a health care professional, this simple test screens people for the signs of neurological compromise. The premise of the assessment is presenting the client with a piece of paper that contains a predrawn circle and asking them to place the numbers commonly seen on a clock face within that circle and point the hands to 10 minutes after 11 o'clock. Significant misrepresentation of the requested time or disorganization of numbers may indicate a cognitive deficit.
- Mini-mental state examination—Administered by a health care professional, this 11-question tool evaluates five areas of cognitive function that include orientation, registration, attention and calculation, recall, and language.
- Other screening tools administered by a health care professional to assess the presence or severity of a behavioral health disorder include:
  - Primary Care PTSD Screen (PC-PTSD)
  - Alcohol Use Disorders Identification Test (AUDIT)—Available in both an interview and self-administered format.
  - Kessler Psychological Distress Scale (K6)—Available in both an interview and self-administered format.
  - Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

An experienced professional will use the results from a variety of physical and psychological assessments to reach a diagnostic conclusion. A psychological diagnosis should

be based on confirmed data. Data elements should include the results of an independent medical evaluation, personal interviews, a detailed review of all available psychiatric records, and the administration of a comprehensive set of medical and psychological tests to confirm or rule out a diagnosis. The review of such standardized psychological data allows others to examine the objective basis for the diagnosis and confirm or refute the conclusions.

Another evaluation that may be performed to assess cognitive impairment and functioning is a neuropsychological assessment. Performed by a neuropsychologist who has knowledge and expertise regarding the interrelationship between the central nervous system and demonstrated cognition and behaviors, this comprehensive series of tests may include an assessment of:

- Reasoning and problem solving
- Academic skills
- Visual-spatial organization and motor skills
- Emotions, personality, and behaviors
- Short and long-term memory and attention
- Language
- Planning and organization

The evaluation process may include a specific set of examinations such as the Halstead-Reitan Neuropsychological Test Battery or a variety of individual assessments including Wechsler Intelligence Scales, Aphasia Examinations, the Hooper Visual Organization Test, Trail Making Tests, Wechsler Memory Scales, Mini-Mental State Exam, Hand Grip Strength, and Myers-Briggs Type Indicator.

A neuropsychological evaluation assists in establishing specific cognitive and behavioral diagnoses and dysfunction, offering a pathway for targeted treatment and providing a baseline of function to facilitate an assessment of progress as the client moves through the health care continuum.

PSYCHOSOCIAL ASPECTS OF CHRONIC ILLNESS AND DISABILITY

Chronic Disease

According to the CDC, approximately half of all adults in the United States have been diagnosed with at least one chronic disease, with one in four adults reporting the presence of two or more chronic health conditions. Chronic diseases have been identified as the direct cause of seven in ten deaths in America, with an estimated 86 percent of all health care costs in America spent on treating chronic disease. This epidemic of chronic disease is not peculiar to the United States. According to the WHO, chronic diseases account for almost 60 percent of deaths and 43 percent of the burden of disease worldwide, and those numbers are expected to rise to 73 percent and 60 percent, respectively, by 2020.

Chronic diseases and conditions that are prevalent in the United States and throughout the world include the following:

- Arthritis
- Alzheimer's disease and other forms of dementia
- Cancer
- Cardiovascular diseases including heart disease, hypertension, and stroke

- Depression and other behavioral health diagnosis
- Diabetes
- Hepatic disorders
- Obesity
- Respiratory disease including chronic obstructive pulmonary disease and asthma
- Renal disease

The CDC has reported that two chronic conditions, heart disease and cancer, account for almost half of all deaths in America. Two other disease states, arthritis and obesity, have been recognized as the leading causes of disability in the United States. While obesity is often considered to be a risk factor rather than a true disease state, the incidence of this health concern in America has dramatically increased over the past 25 years. Based on data from the National Health and Nutrition Examination Surveys, the self-reported rate of obesity as defined as a body mass index ≥ 30 kg/m^2 was 36.5 percent among U.S. adults and 17 percent among children aged 2 to 19 during 2011–2014. This growing epidemic of obesity perpetuates the incidence of chronic disease and disability, prompts annual health care costs of $147 billion (in 2008 dollars), and is a leading cause of preventable death.

Other lifestyle risks that contribute to the development of chronic disease may include:

- Reduction in or lack of physical activity
- Tobacco use
- Alcohol and substance misuse
- Poor diet
- Chronic stress

Because poor lifestyle choices are often key contributors in the development of chronic disease states and conditions, the case manager endeavors to work in partnership with the client, family, and other members of the health care delivery team to advance the ability of the client to effectively manage the chronic illness or condition. An integrated care management approach to support the client in achieving enhanced disease management begins with a comprehensive assessment process that seeks to identify client-specific biopsychosocial challenges and needs. The case management plan that is developed subsequent to that assessment includes methods for presenting education in a manner that is appropriate based on the client's health literacy and cultural values or beliefs, advancing the client's quality of life, supporting the client in the development of individual goals, and promoting the client's ability to achieve those goals.

Disease management is a name that is sometimes utilized to refer to case management interventions provided to clients who present with a chronic disease or condition. CMSA defines disease management as a "subset of case management in which health-related assistance, characterized by education, health facilitation, care coordination, and client/patient advocacy, is given to all collaborating clients/patients within a population who have one or more selected chronic health conditions by licensed and trained health professionals, usually nurses and social workers, with the goal of reversing barriers to improvement and stabilizing health by connecting client/patient assessment findings to a plan of care." Health coaching or wellness coordination is also considered to be a subset of the case management process that is defined by CMSA as a process that assists clients who are at risk for development of health conditions or complications from existing conditions to "understand (and implement) habits of healthy behavior". Another term that might

be utilized to describe the process for coordinating care for clients with a chronic disease or condition is patient navigation. One definition of patient navigation is provided by CMSA and states that patient navigation is "the process of helping clients/patients find needed health care providers, health-related services, and health impacting non-clinical support in a complicated health care system, health inhibiting personal situations, and destructive living environments so that they can accomplish the goals of a care plan."

Although there may be multiple pathways or processes for assisting clients in managing their chronic disease or condition, the first step is to understand that a diagnosis of any illness, injury, or disease can be an agent of change for the client, not just in the physical sense but also psychologically. The illness does not need to be as "catastrophic" as metastatic cancer to cause serious changes in a person's life. A carpenter who suffers from arthritis of the hands, a dancer who suffers from vertigo, and a professional athlete who injures a knee are examples of clients whose injuries, although not considered catastrophic by most, have serious effects beyond the physical realm and into the social and psychological spheres. These clients have not just experienced an illness or painful injury, they have also lost careers, hopes, dreams, social status, and income. As a further example, a father of three who because of illness is no longer the breadwinner for the family experiences more than the pain and disability of his illness; he also suffers the loss of self-respect, social status, and independence.

Case managers who hope to intervene successfully in these situations must assess the effects of the illness or injury beyond the client's physical self. The assessment must explore what limitations, disabilities, and effects on sense of self, relationships, employment, interests, hopes, and aspirations this illness brings. As a result of these life changes precipitated by major illness and injury, clients commonly experience

- Loss
- Anger
- Fear and/or anxiety
- Depression
- Dependency

If anticipated by the case manager, and identified in a timely manner, these reactions can be addressed with education, support, counseling, and, in some cases, medication. During the initial and ongoing assessment processes, the case manager not only evaluates the client's health care status but also assesses the client's individual response, physical, emotional, financial, and social, to the diagnosis of a compromising injury or chronic disease state.

The delivery of care management interventions for the client who has been diagnosed with a chronic disease should, therefore, employ a holistic approach that considers the physical, psychological, and social aspects of care. The case management process assesses the client's biopsychosocial needs and challenges; identifies each component of the health care management plan and utilizes that information to develop and implement a client-specific care management plan; facilities the delivery of necessary education, care components, and services; supports the client in making informed decisions and establishing health care goals; identifies resources that may contribute to timely goal achievement; establishes open lines of communication with all members of the disease management team including the client, family, and caregivers; empowers and engages the client in the effective management of his or her disease state; and, seeks to promote client self-advocacy through and across each transition of care.

RESOURCES FOR THE UNINSURED OR UNDERINSURED

Both the need for resources for the uninsured or underinsured and the availability of those resources are significant. The challenge for the case manager is bringing the pieces together. That is, connecting the right client to the right resources that will mitigate the client's need for health care services or physical necessities such as shelter, nutrition, or emotional support. Since the passage of a number of federal legislative actions, the number of nonelderly uninsured in the United States has diminished from a high of 20 percent in 2013 to approximately 12 percent in 2016. Although 19 million Americans have gained health care insurance since 2013, at least 27 million remain uninsured.

Although the uninsured may cite a variety of reasons for not obtaining insurance coverage, the most common reason is cost followed by the lack of an employer-sponsored plan, immigration status, an inability to navigate the enrollment process, and a conscious decision to opt out of insurance coverage.

While the term *uninsured* indicates the lack of insurance, the term *underinsured* refers to someone who has insurance but that specific health care policy has out-of-pocket expenses such as deductibles and copays that place the client at significant financial risk. The premiums of some health insurance policies are kept affordable by transferring some of the financial risk for care to the client as demonstrated by an annual deductible of $5,000 for an individual and $10,000 for a family. If the definition of underinsured is out-of-pocket costs, excluding premiums, over the prior 12 months equal to 10 percent or more of household income; or out-of-pocket costs, excluding premiums, equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level, an individual would require an annual income of at least $50,000 or $100,000 for a family to avoid being considered underinsured.

When deductibles are high, clients may avoid routine health care services such as physician visits, prescriptions, or examinations including diagnostic tests. This may perpetuate the cycle of forgoing routine and preventive health services due to cost and the client may only seeking physician services or interventions when a disease has exacerbated to a state in which hospitalization and/or intensive treatment is necessary.

An essential aspect of the case management process is the identification of and removal of barriers to obtaining the care necessary to assist the client in reaching desired health care goals. If one of the identified barriers is related to either a lack of insurance coverage or limited coverage, the case manager works to identify alternative pathways for accessing care and resources for financial assistance.

Some patients may not be aware of resources that are available to support them in obtaining insurance coverage or reducing their financial risk if underinsured. Some resources the case manager might consider presenting to the client include:

- Connect the client to navigators or insurance application or Medicaid enrollment counselors who might assist them in identifying coverages that meet their needs physically, psychosocially, and financially
- Explore client-specific options for care delivery including free clinics, and income-based health care services from health care systems including acute care facilities and physicians
- Referral to prescription assistance programs
- Referral to hospital billing departments for information regarding financial assistance or to negotiate the costs of care

- Connect the client to disease-specific organizations that may offer financial support or funded pathways for receiving health care services
- Referral to faith-based charitable organizations and other sources of assistance such as veteran or fraternal organizations

Additionally, the case manager can maintain an awareness of federal poverty levels so that appropriate referrals can be facilitated to federal- and state-funded programs. United States Federal Poverty Guidelines are published each year in the *Federal Register* and are available at www.healthcare.gov/glossary/federal-poverty-level-FPL.

SPIRITUALITY AS IT RELATES TO HEALTH BEHAVIOR

No one universal definition of spirituality exists. Spirituality can, therefore, be defined in many ways including:

- A belief in a higher power that is greater than oneself
- An awareness of the purpose and meaning of life that leads to the development of personal values
- A sense of connection with all living creatures
- A method for finding meaning, hope, comfort, and inner peace
- The manner in which an individual might experience connectedness to the moment, to self, to others, to nature, and to the significant or sacred
- Values that promote self-knowledge and an enhanced understanding of the cycle of life
- A method for coping with serious illness, injury, or death

Spirituality is individual and unique to each person who professes a spiritual nature. Religion is a formalized or structured group of principles and practices related to sacred beliefs. Religion may encompass not only beliefs but also sets of doctrines, rituals, values, and obligations.

In health care environments, these two terms are often used interchangeably and, yet, the sole definition that is viable is based on the meaning of spirituality or religion that the client brings to the health care delivery experience. These beliefs present an opportunity to dispel the mechanical nature of health care delivery and advance personalized care that is respectful of the principles, philosophies, and values identified by the client.

Beliefs that are specific to formalized religion reflect the values and beliefs of each unique group including:

- Behaviors that are considered taboo or offensive such as alcohol use, consumption of certain foods, use of blood or blood products, certain procedures or treatments such as abortions, birth control, examination or interventions provided by health care professionals of the opposite gender, and removal of artificial hydration or nutrition
- Behaviors that seek to advance healing such as prayer, reading of religious texts or scriptures, and performance of healing rituals such as blessings or rites that seek to remove demons or other evil influences, use of herbs that are deemed sacred to treat illness or maintain health, positive thinking, and meditation

Additionally, religious groups may be an important source of community services and emotional support.

All health care professionals are charged with respecting a client's right to care that reflects and respects the client's cultural, religious, spiritual, and psychosocial beliefs and values. The case manager consistently performs a comprehensive assessment that includes a focus on cultural, spiritual, and religious beliefs. Those beliefs and values are considered as each case management plan is developed and honored as the client moves through each transition of care.

Spiritual and religious beliefs may be considered by some clients to be personal information and those clients may be reluctant to discuss their beliefs and spiritual preferences. It may, therefore, be necessary for the case manager to develop a set of open-ended questions to assist in compiling a spiritual history for the client. Topics to be included in the assessment include:

- Spiritual or religious beliefs that might influence the type of health care interventions provided
- Religious affiliation and supportive services that might be available from that community of care
- Desire to meet with a chaplain, spiritual counselor, or pastoral care representative
- Spiritual or religious practices that might diminish the level of stress or provide comfort such as prayer or meditation

The HOPE questions offer another method for assessing a client's spirituality. These questions are often utilized to develop a greater understanding of the client's spirituality and religious preferences. Based on the pneumonic, HOPE, the categories for exploring spirituality include:

H Sources of hope, meaning, comfort, strength, peace, love, and connection
O Organized religion preference, if any
P Personal spirituality and practices
E Effects on medical care and end-of-life issues

Spirituality can offer comfort and meaning to a client's life and provide a coping mechanism for his or her suffering. A client's spirituality can affect his or her quality of life, medical decision making, and medical outcomes. Therefore, spirituality has a bearing on clinical care and case management.

The SOP as presented by CMSA state, "All clients are unique individuals and the professional case manager engages them without regard to gender identity, race or ethnicity, and practice, religious, other cultural preferences, or socioeconomic status." This ethical mandate supports a case management responsibility to understand and accept the spiritual and religious values and beliefs of each client even when those tenets of spirituality or religion are in conflict with the case manager's individual beliefs.

SUPPORT PROGRAMS (E.G., SUPPORT GROUPS, PASTORAL COUNSELING, DISEASE-BASED ORGANIZATIONS, AND BEREAVEMENT COUNSELING)

Although numerous definitions of support groups exist, a common definition is a group of people with common experiences or concerns who provide each other with encouragement, comfort, and advice. A support group may be organized or loosely structured, but

each group seeks to provide its members with help and companionship in meeting the physical or behavioral problems in their lives or the lives of a loved one.

It is estimated that more than 500,000 support groups are currently available in the United States. These groups address disease-specific illnesses, addiction, domestic violence, death and dying, and grief.

Peer support groups are composed of individuals that share a specific concern or life experience. The group is formed based on the concept of equal status with each member of the group sharing some responsibility for group tasks and maintenance. Shared information serves as the foundation of these groups, with members benefiting from a collective body of knowledge and experiences.

Professionally facilitated support groups are generally organized, managed, and led by a health care professional. The facilitator is charged with managerial tasks and does not generally share the problem or concern of the members of the group. Another type of support group is an online group. This may be the least formalized of support groups, with members participating in real time (synchronous) or asynchronous in which message responses are posted as received over time by group members. The value of any group is most closely associated with the sense of connection that is offered to the members, the accuracy of information provided, and the ability of the group to support and sustain each other through discussion of common issues or major life changes.

The SOP from CMSA define support systems as those indicated by the client that might include a biological relative, spouse, partner, friend, neighbor, colleague, health care proxy, or any individual supporting the client. Some clients might identify group participants as key members of their community support team. It is, therefore, important to assess the contributions made by the group to the client's ability to be successful as the client moves through the health care continuum.

WELLNESS AND ILLNESS PREVENTION PROGRAMS, CONCEPTS, AND STRATEGIES

Mid-century health care delivery in America was primarily focused on the treatment of an identified disease. Wellness or disease prevention was most closely associated with vaccinations and other public health issues including controlling disease epidemics and advancing public safety. In the 1970s, a greater focus on wellness took root with unhealthy behaviors becoming part of the public focus. Following the release of the surgeon general's report on smoking, the American population began to more fully realize the value of health and to consider steps the average American might employ to advance a healthy state and achieve wellness.

Today, wellness is a term that refers to many dimensions of health—occupational, financial, environmental, social, spiritual, intellectual, emotional, and physical. Wellness is considered to be a multidimensional state that reflects the existence of positive health as exemplified by quality of life and a general sense of well-being. Other definitions of wellness focus on the process of becoming aware of and following steps that advance a longer and more successful existence. SAMHSA refers to wellness not as the absence of disease, illness, or stress but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

Health promotion and disease management or prevention strategies are the primary elements of a formalized wellness program. Offered by some employers, health plans and

communities as a response to an epidemic of chronic disease associated with lifestyle choices, wellness programs seek to advance both primary and secondary disease prevention. Primary prevention is generally focused on encouraging healthy behaviors in order to minimize the incidence of diseases such as diabetes and cardiovascular disease. Secondary prevention utilizes many disease management concepts such as providing patient education, fostering positive health behavioral change, and encouraging adherence and persistence with prescribed therapies to improve disease control and minimize disease-related complications.

Wellness programs frequently offer participants a variety of benefits including lower deductibles and/or premiums or other incentives to actively participate in the program. Many programs begin with a comprehensive self-administered health risk assessment in combination with a clinical screening to obtain biometric data. That data is then utilized to develop a client-specific wellness plan designed to move the client from being a passive recipient of intermittent health care interventions to becoming an active member of a health management team that focuses on the development and implementation of client-focused strategies to improve health status, reduce negative health care outcomes, and enhance quality of life and achievement of health goals.

These programs may also offer other health promotion activities such as on-site health clinics, yoga, tai chi, and other fitness programs, healthy food options in employee cafeterias, weight loss support, smoking-cessation resources, employee assistance programs, health screenings, and on-site vaccinations. Formalized wellness plans may focus on advancing a healthy balance of mind, body, and spirit that results in an overall feeling of well-being.

Some clients have developed personal wellness programs that are considered to be a conscious, self-directed, and evolving process of achieving full potential. The SAMHSA website offers a number of tools to assist individuals in maintaining a healthy lifestyle, partnering with their primary care physician, and developing a process for consistently seeking information regarding any risks for developing an illness or managing a chronic disease that has been identified. These resources address a holistic approach to disease prevention and management that includes a focus on emotional and general health, diet and nutrition, smoking and tobacco cessation, and stress management.

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Test Questions

1) **The framework for providing a pathway for the client to obtain, process, and understand health information and necessary services that are specific to that client's needs is:**
   A. Client education
   B. Client activation
   C. Health literacy
   D. Client empowerment

2) **Self-efficacy is**
   A. Client activated behaviors that promote the achievement of physician-coordinated outcomes of care.
   B. Established to coordinate the delivery of care across the health care continuum.
   C. The extent to which people believe they are capable of performing specific behaviors in order to attain certain goals.
   D. An established goal for care as defined by The Joint Commission National Safety Goals.

3) **Empowering the client to problem solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes is a case management**
   A. Standard of care
   B. Function
   C. Responsibility
   D. Task

4) **A 50-year-old client has experienced a cerebrovascular event that prompted significant right-sided weakness. His rehabilitation plan includes a variety of therapies to advance the client's long-term goal of becoming independent in all activities of daily living. Although he fully participates in physical therapy, he refuses all attempts by the occupational therapist to advance his ability to eat independently. As the case manager, what assessment might assist in understanding and addressing the behavior displayed by the client?**
   A. Patient Health Questionnaire-9 with appropriate depression management strategies.
   B. A neuropsychological evaluation with implementation of recommended targeted therapies.
   C. Understanding cultural beliefs and advancing a treatment plan that is reflective of those beliefs.
   D. Identifying the client's fears and challenges with referral to a stroke survivor support group.

5) **A unique method of assessing the degree of client engagement and empowerment is**
   A. Motivational interviewing
   B. Integrated care management
   C. The Patient Activation Measure
   D. The Health Management Scale

6) **Common elements for case management assessment include physiological functioning, psychosocial functional, cultural factors, and**
   A. Health literacy and linguistic factors
   B. Benefit determinations
   C. Ability to return to preillness or preinjury function level
   D. Affirming patient dignity and values

7) **Providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs is the foundation of**
   A. The Standards of Practice for Case Management
   B. The National CLAS Standards
   C. The cultural competence requirements presented by The Joint Commission
   D. The Conditions of Participation presented by the Center for Medicare and Medicaid Services

8) **A case manager is told by a patient with a spinal cord injury, "I feel like half a person." The case manager's response should be to**
   A. Distract the client from self-pity
   B. Help the client explore personal feelings
   C. Ignore the comment
   D. Actively discourage negative comments

9) **A primary step in the case management process that seeks to identify the patient's current biopsychosocial status, patient-centered goals, and a pathway to achieve those goals is**
   A. Planning
   B. Care coordination
   C. Assessment
   D. Evaluation

10) **The capacity to obtain, process, and understand basic health information is**
   A. Adherence
   B. Cultural competence
   C. Linguistic ability
   D. Health literacy

11) **The opportunity to converse with the patient in a conversational manner is enhanced through the use of**
   A. A script for required questions
   B. Sympathetic responses
   C. Time limits for the assessment discussion to prevent question fatigue
   D. Open-ended questions and maintaining perspective

12) **Established by the Older Americans Act to respond to the needs of Americans over age 60, this community-based organization provides a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best.**
   A. AARP
   B. National Council for the Aging
   C. My Aged Care
   D. Area Agency on Aging

13) An authoritative compilation of common definitions and criteria sets for classifying mental disorders published and maintained by the American Psychiatric Association is
A. *The International Classification of Diseases*, Tenth Edition, Clinical Modification
B. *The Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition
C. *The Current Procedural Terminology* Code Set
D. *The Quantitative Psychiatric Diagnostic Evaluation Procedure Code*

14) A communication exchange for the purpose of reaching agreement is
A. Critical thinking
B. Negotiation
C. Conflict resolution
D. Collaboration

15) Disease management programs emphasize prevention of disease-related exacerbations and complications through the utilization of evidence-based practice guidelines and
A. Performing routine cost–benefit analyses
B. Patient empowerment strategies
C. Risk management assessments
D. Pay-for-performance incentives

16) As a case manager involved in a conflict that cannot be resolved, the case manager should
A. Remove herself/himself from the case
B. Assign new people to the interdisciplinary team for that patient
C. Request the family make the final decision to resolve the conflict
D. Investigate the reason the conflict is unable to be resolved

17) A 67-year-old client with a 60-year history of smoking cigarettes is diagnosed with stage 2 or moderate chronic obstructive pulmonary disease. The client has attempted to quit smoking several times and has been unsuccessful. Which of the following tools might be useful in determining her current motivation for smoking cessation?
A. Brief Medication Questionnaire (BMQ)
B. Patient Health Questionnaire (PHQ-9)
C. The Readiness Ruler
D. REALM-R

18) A homeless client is statused to observation following initial treatment in the emergency department for an exacerbation of heart failure. The interdisciplinary team works in partnership with the client to develop a transition plan that advances the client's ability to receive appropriate treatment and medication management in a local outpatient clinic. The interaction between members of the team is referred to as
A. Care coordination
B. Collaboration
C. Transitional care management
D. Multidisciplinary patient navigation

19) The most important element of care transitions is
A. Communication
B. Transportation
C. Completing all aspects of confirmation regarding medical necessity
D. Identifying the barriers to discharge

20) Client activation includes

A. The knowledge, skills, and confidence a person has in managing his or her own health and health care.
B. Eliciting health behavior change by helping clients to explore and resolve ambivalence.
C. The primary process that encourages clients to gain greater control over decisions and actions affecting their health.
D. Imparting information to the client and his or her caregivers that will advance positive health behavior.

21) When the patient chooses not to adhere to the case management plan, the case manager should first

A. Obtain an order for a psychological evaluation.
B. Document the nonadherence in the medical record.
C. Ask the physician to speak to the patient and family about the behavior.
D. Discuss the nonadherent behavior with the client.

22) Conflict resolution styles include

A. Competing and collaborating
B. Competing, collaborating, and compromising
C. Avoiding, accommodating, and competing
D. Competing, collaborating, compromising, avoiding, and accommodating

23) Unreasonably ordering an individual around or treating an individual like a servant or child is a form of

A. Neglect
B. Abuse
C. Disparagement
D. Derogation

24) A process most closely associated with the transfer of information from a sender to a receiver is known as

A. Transitional care coordination
B. Clinical informatics
C. Linguistic conveyance
D. Communication

25) A 73-year-old Army veteran is diagnosed with type 2 diabetes and peripheral neuropathy. He advises the case manager that he is unable to afford the Part D copayment for current medications. The case manager might consider supporting the client with a referral to

A. Medicare Part D Extra Help
B. A Veteran Service Officer
C. The Civilian Health and Medical Program of the Department of Veterans Affairs
D. Medicaid

26) A directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence is:

A. Brokering
B. Motivational interviewing
C. Adherence analysis
D. Negotiation

27) The role of the case manager in every conflict resolution process is focused on
A. Establishing agreement between the conflicted parties
B. Documenting the confirmation of resolution
C. Advocacy
D. Negotiating a resolution

28) The advancement of health education and health promotion to enhance the well-being of individuals and to facilitate the achievement of their health-related goals is
A. Health coaching
B. Motivational interviewing
C. Disease management
D. Health care coordination

29) The teach-back technique is utilized to advance the goals of
A. Patient empowerment
B. Shared decision making
C. Patient education
D. Advancing health literacy

30) The cognitive and social skill that determines the motivation and the ability of individuals to gain access to, understand, and use information to promote and maintain good health is
A. Cultural competency
B. Patient activation
C. Decisional capacity
D. Health literacy

31) A personality disorder is defined as
A. A disorder that causes sufferers to experience unexpected, severe panic attacks that begin with a feeling of intense apprehension, fear, or terror.
B. A disorder characterized by periods of extreme elation, unbounded euphoria without sufficient reason, and grandiose thoughts or feelings about personal abilities.
C. A mental disorder characterized by thoughts, images, or impulses that recur or persist despite efforts to suppress them.
D. A chronic, inflexible, maladaptive pattern of perceiving, thinking, and behaving that seriously impairs an individual's ability to function in social or other settings.

32) A process of selecting a course of action from among multiple alternatives that minimally includes disclosure, competence, and understanding is:
A. Consent
B. Informed decision making
C. Shared decision making
D. Health literacy

33) A client with a history of nonadherence to the prescribed treatment plan for the management of a psychiatric disorder might benefit from this subset of case management interventions.
A. Transitional care management
B. Care coordination
C. Integrated case management
D. Behavioral health case management

34) A client who was injured in a motor vehicle accident begins to experience frequent and exaggerated busts of anger and is consistently late to scheduled therapy visits due to challenges in accessing public transportation systems. The case manager in collaboration with the client and the treatment team might facilitate additional testing including

A. Administration of a Patient Health Questionnaire-9 with appropriate depression management strategies.
B. A comprehensive neuropsychological evaluation.
C. Administration of both a clock drawing test and a mini-mental state examination.
D. Establishing a level of function based on the Rancho Los Amigos Scale.

35) The client is unable to express her preferences for care due to cognitive impairment. Her husband is in conflict with her children from a previous marriage and no advanced directives have been identified. What initial action might the case manager employ to advance the decision-making process?

A. Advising the children that an informed decision-making process is the sole responsibility of the husband.
B. Facilitate a referral to the risk management team.
C. Initiate a family conference to seek resolution of the conflict.
D. Contact the primary care physician, when available, to confirm the lack of an advanced directive.

36) A client who has been diagnosed with heart failure with a reduced ejection fraction is referred to a cardiac rehabilitation program. The client and family are reluctant to participate in the program due to financial considerations as well as transportation issues. Which might be an appropriate action for the case manager to take?

A. Document the client's reluctance to participate in the prescribed postacute recovery plan.
B. Collaborate with the cardiac rehabilitation team to seek alternative methods of payment and transportation.
C. Consider development of a cardiac rehabilitation plan that might be provided as an aspect of home health.
D. Offer the client and their support system a list of inpatient rehabilitation programs that might offer cardiac rehabilitation services.

37) Judging other cultures or groups relative to his or her own particular ethnic group or culture, especially with concern to language, behavior, customs, and religion is

A. Cultural compromise
B. Essentialism
C. Xenocentrism
D. Ethnocentrism

38) An effort across transitional services including paramedics, acute care facilities, and postacute environments of care with a goal of recognizing and adhering to client wishes regarding end-of-life care is referred to as a:

A. Physician Order for Life-Sustaining Treatment
B. Durable power of attorney for health care
C. Living will
D. Five Wishes

39) An inability to achieve a balance between meeting a client's needs and maintaining the client's own ability to function may be indicative of

A. A dysfunctional family
B. A maladaptive family
C. A hierarchical treatment team
D. Level Four of the Patient Activation Measure

40) The active process of realizing the need for change and an intention to move toward that change is

A. Precontemplation
B. Contemplation
C. Preparation
D. Deliberation

41) Associated with a set of interactive techniques adapted from a client-centered approach to elicit and strengthen motivation to change, a technique incorporating both responses and behaviors in a manner that is client-specific, culturally competent, and appropriate is

A. RULE
B. EMPOWER
C. ENGAGE
D. OARS

42) A communication pattern that includes the use of stance, gestures, eye behavior, and other posturing by an individual to convey a message is referred to as

A. Kinetics
B. Paralanguage
C. Haptics
D. Chronemics

43) An intervention strategy that allows someone who is experiencing crisis to detail his or her perspective of the crisis and consider the steps necessary to manage or control the crisis may include

A. An unbiased and nonjudgmental assessment of the crisis.
B. Implementation of a crisis management plan that advances biopsychosocial function.
C. The process of validation and ventilation.
D. The timely identification of the underlying disruptor of normalcy.

44) Arousal or reactivity symptoms as represented by feeling tense or on edge, angry outbursts, or difficulty sleeping are most commonly associated with a diagnosis of

A. Bipolar disorder
B. Panic disorder
C. Depression
D. Posttraumatic stress disorder

45) Ms. Brown is a 72-year-old female who arrives at the emergency department with signs of malnutrition and dehydration. The client denies any health problems although a gangrenous wound is seen on her right lower extremity. The client states she is a "loner" but appreciates her neighbors who recently helped her to "spruce up her yard." She is a frequent caller to a local talk radio station and spends most of her day reading books from her local library, which she visits at least weekly. Her behavior may represent a type of

A. Self-neglect
B. Cognitive impairment
C. Abuse
D. Psychosis

46) The manner in which an individual might experience connectedness to the significant or sacred, to the moment, to self, to others, and to nature is a component of

A. Religion
B. Dualism
C. Existentialism
D. Spirituality

47) A client who is morbidly obese with a body mass index of 34 expresses a strong desire to lose weight as well as stating a reluctance to decrease his caloric intake is

A. Expressing ambivalence
B. Exhibiting components of the self-determination theory including autonomy, competence, and relatedness
C. Participating in a form of change talk
D. Expressing a readiness to change

48) A subset of case management in which health-related assistance, characterized by education, health facilitation, care coordination, and client/patient advocacy, is given to all collaborating clients/patients within a specific population as defined by CMSA is

A. Patient navigation
B. Health coaching
C. Integrated care management
D. Disease management

49) A process that advances the client's ability to think critically and act autonomously is

A. Patient engagement
B. Patient education
C. Health promotion
D. Patient empowerment

50) As defined by the Substance Abuse and Mental Health Services Administration, this concept represents the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.

A. Well-being
B. Wellness
C. Chronic disease management
D. Holistic life management

NOTES

Answer Key

1) ANSWER: A

Client empowerment is considered a process through which people gain greater control over decisions and actions affecting their health. Client activation is the knowledge, skills, willingness, and confidence a person has in managing his or her own health and health care. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. While client education is closely associated with each of these terms, client education is the sole concept that includes a specific process or path by which the client comes to comprehend his or her physical condition and self-care. Another definition of client or patient education is the process by which health professionals and others impart information to clients that will alter their health behaviors or improve their health status.

2) ANSWER: C

Self-efficacy impacts people's emotions, cognition, behaviors, and motivation to initiate and sustain identified health care management activities. It is an ability to believe they can be responsible for their own decisions and lives. While self-efficacy may be considered a predictor of behavior and motivation, it is not related to either care coordination or physician-coordinated outcomes of care. Self-efficacy is not considered to be one of the National Patient Safety Goals presented by The Joint Commission.

3) ANSWER: B

The Standards of Practice for Case Management as presented by the Case Management Society of America state, "The role functions of professional case managers may include counseling and empowering the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes." Functions are defined as a grouping or a set of specific tasks or activities within the role. An activity is a discrete action, behavior, or task a person performs to address the expectations of the role assumed.

4) ANSWER: C

Clients of the Muslim religion may believe that the left hand is unclean and used only to remove impurities or clean oneself. Some Muslim teachings state, "If one of you eats, he should eat with his right hand. And if he drinks something, he should drink with his right hand. For indeed, Satan eats and drinks with his left hand." Because the client participates in other aspects of his rehabilitation plan, it might be appropriate to explore the reason the client is reluctant to use his left hand. If culture is the reason, the team including the client, his family, and his religious leader might meet to develop a plan for independence that is acceptable to the client.

5) ANSWER: C

According to the Case Management Society of America Glossary of Case Management Terms, patient activation is "the degree to which a client becomes actively involved in trying to improve his or her own health". The Patient Activation Measure is a tool that gauges the level of engagement through a comprehensive assessment of each unique client's knowledge, skills, and

confidence required to manage his or her own health and health care. Motivational interviewing is a technique or counseling approach utilized to affect health behavioral change. Integrated case management employs a comprehensive biopsychosocial assessment to incorporate each dimension into an approach for the delivery of a coordinated continuing health care plan.

6) ANSWER: A

The Case Management Society of America's Standards of Practice for Case Management state the role of the case manager includes "conducting an assessment of the client's health, physical, functional, behavioral, psychological, and social needs, including health literacy status and deficits, self-management abilities and engagement in taking care of his or her own health, availability of psychosocial support systems including family caregivers, and socioeconomic background". Benefit determinations are the sole responsibility of the payor and not an element of the assessment process. Although client dignity and values are significant as are preinjury levels of functioning, these elements are not specifically detailed within accepted Standards.

7) ANSWER: B

This statement is supported within the National Culturally and Linguistically Appropriate Services in Health and Health Care Standards. These Standards were developed by the U.S. Department of Health and Human Services to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services. Although a focus on cultural competency is a component of the Standards of Practice for Case Management and The Joint Commission Accreditation Standards, these requirements are a primary foundation of either document.

8) ANSWER: B

The case manager should permit and encourage the patient to explore his or her feelings without judgment, punishment, or rejection. Distraction, avoidance, discrimination, and/or discouragement are not aspects of a professional practice of case management.

9) ANSWER: C

Assessment is defined by the Case Management Society of America (CMSA) as a systematic process of data collection and analysis involving multiple elements and sources. According to CMSA's Standards of Practice, an assessment minimally involves "data gathering, analysis, and synthesis of information for the purpose of developing a client-centric case management plan of care". Information gained during the assessment process is utilized in collaboration with the client, family, and other members of the multidisciplinary team to develop a case management plan. That plan includes identified case management and client-specific goals and a pathway to achieving those goals. Care coordination is defined by the Commission for Case Manager Certification as "the process of organizing, securing, integrating, and modifying the resources necessary to accomplish the goals set forth in the case management plan".

10) ANSWER: D

Title V of the Patient Protection and Affordable Care Act of 2010 defines health literacy as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

11) ANSWER: D

The ability to assess and converse with a patient is enhanced through the use of open-ended questions. This type of question generally facilitates a deeper discussion as the client is required to respond with a statement rather than offering a brief positive or negative answer. Additionally, open-ended questions encourage the client to speak more than they listen, offer an opportunity for the interviewer to remain nonjudgmental, and support open lines of communication. When

open-ended questions are asked in an environment that fosters a perspective of understanding and acceptance, the client is more likely to offer valid responses in a conversational manner. Scripted conversations as well as time-limited assessments may have a limited ability to identify client-specific concerns or barriers to advancing goal achievement. These conversations may focus more on knowledge considered necessary by the interviewer rather than taking into account the needs and wants of the client. And, while sympathetic responses may be useful in motivational interviewing, those responses do not generally enhance the conversational nature of the communication process.

12) ANSWER: D

According to the National Association of Area Agencies on Aging, the Area Agencies on Aging (AAAs) were formally established in the 1973 Older Americans Act as the "on-the-ground" organization charged with helping vulnerable older adults live with independence and dignity in their homes and communities. More than 600 individual agencies strong, AAA is a component of most community-based care transition programs with a focus on affecting more appropriate transitions of care in order to prevent or minimize readmissions to acute care.

13) ANSWER: B

An accepted source for standardized criteria for the diagnosis and classification of psychiatric disorders is the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5). Published and maintained by the American Psychiatric Association, DSM-5 presents three distinct categories: a diagnostic classification, diagnostic criteria sets, and a descriptive text. The classifications for behavioral health diagnoses detailed within DSM-5 were recently adapted by the *International Classification of Diseases*, Tenth Edition, Clinical Modification (ICD-10). ICD-10 employs an alphanumeric system to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with health care delivery throughout the world. It spans the full scope of diagnoses including both physical and psychological. The Current Procedural Terminology system is a numeric code developed, maintained, and copyrighted by the American Medical Association to provide a standardized method for procedural coding and billing. It is not a system for classification of disease.

14) ANSWER: B

Negotiation is defined as a communication process that advances the ability to achieve a mutually acceptable agreement. Negotiation skills are an important component of the conflict resolution process although not every conflict is resolved through mutual agreement. Collaboration may be an element of negotiation but a spirit of collaboration does not consistently include resolution of the primary sources of conflict.

15) ANSWER: B

Disease management for a client with a chronic disease state includes empowering the client and his or her support system to become fully engaged in processes that promote joint responsibility for achieving agreed-on client-identified goals. This includes providing the client with appropriate information that facilitates a greater understanding of the disease state, the steps necessary to maximize efficient management of that illness, and an enhanced appreciation of the value of becoming an active participant in all processes that advance effective disease control. Cost–benefit analyses, risk management assessments, and pay-for-performance initiatives are often components of a formalized disease management program offered by payers or providers to advance the stated objectives of the program.

16) ANSWER: D

Conflict resolution is a dynamic process of resolving disputes or disagreements with a primary aim of reconciling opposing arguments in a manner that promotes and protects the human

rights of all parties concerned. In some instances, a reasonable solution to the conflict may not be immediately identifiable. In those instances, the case manager seeks to investigate the primary barriers that compromise the ability to obtain resolution or compromise. Once the barriers are identified, the path to agreement may become less complicated and much easier to navigate.

Avoidance and substitution are not preferred options for addressing the conflict. And, mandating a resolution often fails as the conflicting parties may not be able to understand the opposing view or consider any resolution that does not fully encompass their viewpoint.

17) ANSWER: C

Although both the Brief Medication Questionnaire and the Patient Health Questionnaire provide the case manager with information that might assist in the identification of barriers to adherence or health behavioral change, the Readiness Ruler is the only listed tool that can be utilized to assess an individual's motivation with respect to the importance, confidence, and readiness to make a change.

REALM-R is a word recognition test consisting of 11 words and was developed to identify poor health literacy skills.

18) ANSWER: B

The Standards of Practice for Case Management as presented by CMSA state, "the professional case manager should facilitate, coordination, communication, and collaboration with the client, the client's family or family caregiver, involved members of the interprofessional healthcare team, and other stakeholders, in order to achieve target goals and maximize positive client care outcomes." The key term within this statement is *collaboration*.

Collaboration is defined as the act of working together toward a shared goal. A biopsychosocial approach to affecting an appropriate transition of care includes an integrated and collaborative team that advances safe, timely, efficient, effective, equitable, and client-centered care during each health care experience and across each transition of care. This collaborative approach advances a collective ability to support the client throughout necessary treatment.

Care coordination, transitional care, and patient navigation, while demonstrating elements of collaboration, do not represent the shared efforts and common purpose that is evident within a multidisciplinary team that is focused on promoting a continuing care plan that meets the needs and desires of the client.

19) ANSWER: A

Transitional care has been defined by the National Transitions of Care Organization (NTOCC) as "the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change". According to NTOCC, transitional care is a subset of the broader concept of care coordination that reflects a client-accepted plan for care that advances the client's goals, preferences, and full understanding of his or her individual health status. Effective transitions are facilitated by a multidisciplinary team of health care professionals who efficiently communicate aspects of the transitional care plan to all members of the team including the client and his or her support system.

It is not the individual components of the transitional plan that advance the plan's ultimate success but rather the ability to communicate each element of the plan to each team member in every environment of care that encourages the success of the plan.

20) ANSWER: A

Looking to standards that guide a practice of case management, the CMSA Standards detail one function of case management as "conducting an assessment of the client's health, physical, functional, behavioral, psychological, and social needs, including health literacy status and

deficits, self-management abilities and engagement in taking care of his or her own health, availability of psychosocial support systems including family caregivers, and socioeconomic background". Information regarding benefit coverage and any ability to regain preinjury function may augment information gained during the assessment but are not considered common elements for the assessment process.

The assessment process also includes a social component that identifies client beliefs, values, needs, and preferences including cultural and spiritual. Affirmation of dignity is an aspect of every case management intervention and is not specific to the assessment process.

21) ANSWER: D

Although each of the responses may be appropriate at some point during the case management process, the question asks for the first or initial action the case manager might take when partnering with a client who identifies him- or herself as nonadherent. A discussion regarding reported behaviors that are in opposition to or do not reflect the continuing care plan is generally the most appropriate first step as it assesses specific aspects of the behaviors and may identify contributing factors that prompt those behaviors.

22) ANSWER: D

The five most common responses to conflict include avoidance, competition, accommodation, compromise, and collaboration. Avoidance includes sidestepping the issue and even allowing others to address the conflict. Those who are competitive express a desire to win and are often assertive, intimidating, and uncooperative. Accommodation is a tactic of those who are willing to yield, maintain relationships, and promote goodwill rather than pushing for a specific idea or goal. Compromise and collaboration are highly desirable responses to conflict. Those who seek compromise are willing to negotiate and seek middle ground. Collaboration represents a style of cooperation and finding creative solutions to meet the concerns of all parties. Collaboration may facilitate the building of relationships but it requires a period of time for an exploration of each side of the conflict and the development of truly collaborative steps for achieving conflict resolution.

When the case manager is involved in conflict resolution, it might be appropriate to understand the responses of each person who is part of the conflict and their unique method for obtaining resolution.

23) ANSWER: B

Unreasonably ordering an individual around or treating them like a servant is a form of emotional abuse that diminishes a person's sense of dignity or self-worth. Neglect is a form of abuse that is defined as a failure to act or provide that is ultimately the cause of physical or emotional harm. Disparagement and derogation are considered by some to be synonymous, defined as verbal assaults that belittle or address someone or something in a negative manner.

24) ANSWER: D

Communication is defined as the transfer of information from a sender to a receiver. Effective communication is bidirectional and includes a pathway for information sharing between people or devices.

25) ANSWER: B

Based on this question, the only information available is the age of the client and his status as a veteran. Because medical benefits may be available to an honorably discharged veteran, a referral to a Veteran Service Officer might be appropriate. Knowledgeable regarding federal, state, and local veteran's benefits, these individuals are available to assist veterans and their families in a number of ways including compensation/pensions, medical care, military records, grave markers, and veteran home loans. Each state maintains a listing of local Veteran Service

Officers through their individual state departments of veterans' affairs, veterans' services, veterans' benefits, veterans' councils, or veterans' commissions.
According to the U.S. Department of Veterans Affairs, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is available to eligible spouses and children of a veteran who is rated permanently and totally disabled due to a service-connected disability or died as a result of a permanent service-connected disability, was permanently disabled due to a service-connected disability at the time of death, or who died in the line of duty. Veterans themselves are not eligible for CHAMPVA.
In regard to Medicare Part D Extra Help or Medicaid referral, each application for assistance is subject to specific federal or state financial eligibility requirements.

26) ANSWER: B
As defined by Miller and Rollnick in 2009, motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation to change.

27) ANSWER: C
The Commission for Case Manager Certification includes the following description of case management, "it is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes." Additionally, the Standards of Practice for Case Management as presented by the Case Management Society of America state, "The professional case manager performs the primary functions of assessment, planning, facilitation, coordination, monitoring, evaluation, and advocacy. Integral to these functions is collaboration and ongoing communication with the client, client's family or family caregiver, and other health care professionals involved in the client's care."
Both of these statements support the role of a case manager as a client advocate. Advocacy is the only response detailed within this question that is consistently a component of each case management intervention.
When a case manager is a member of the conflict resolution process, negotiating a resolution or establishing an agreement is a goal but not always achieved. Documenting resolution or the lack thereof is a task of the case manager but not a role function of case management.

28) ANSWER: A
Health coaching is a process that "facilitates healthy, sustainable behavior change by challenging a client to listen to his or her inner wisdom, identify values, and transform goals into action to enhance the well-being of the individual". As defined by the CMSA Glossary of Case Management Terms, disease management is "characterized by education, health facilitation, care coordination, and client advocacy" with a goal of reversing barriers to improvement. And, while disease management may advance client-desired outcomes, health coaching is most closely related to the enhancement of client well-being.

29) ANSWER: C
The Agency for Healthcare Research and Quality has detailed the value of the teach-back technique in advancing client education and suggests the use of teach-back whenever an important concept is presented to the client including treatment options, participation in a clinical trial, weighing benefits and risk, or adherence to a treatment plan.
Although the teach-back strategy may contribute to advancing patient empowerment, shared decision making, and health literacy, it primarily advances the goals of the client educational process.

30) ANSWER: D
Health literacy has been defined by the U.S. Department of Health and Human Services, Health Resources and Services Administration as "the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health

decisions". Cultural competency is a process by which individuals and systems understand and respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities.
Decisional capacity represents the ability of an individual to make his or her own health care decisions and patient activation is the knowledge, skills, abilities, and confidence a person may display for managing his or her own health.

31) ANSWER: D

An accepted definition of personality disorder is a chronic, inflexible, maladaptive pattern of perceiving, thinking, and behaving that seriously impairs an individual's ability to function in social or other settings. Anxiety disorder might be defined as a disorder that causes sufferers to experience unexpected, severe panic attacks that begin with a feeling of intense apprehension, fear, or terror.
A disorder characterized by periods of extreme elation, unbounded euphoria without sufficient reason, and grandiose thoughts or feelings about personal abilities is bipolar disorder. And, obsessive-compulsive disorder is characterized by thoughts, images, or impulses that recur or persist despite efforts to suppress them.

32) ANSWER: B

Informed decision making includes the cognitive capacity to receive, understand, and process information in order to formulate a voluntary decision. Shared decision making is a process that advances collaboration between a client and his or her treatment team in order to determine a path for action. It differs from informed decision making in that it is collaborative in nature and advances client understanding of and concurrence with the proposed plan for care. Consent is an agreement but the term *consent* does not imply that the consent provided was based on obtaining adequate and accurate information regarding available courses of action.

33) ANSWER: C

Integrated case management is defined as a subset of care management in which "the longitudinal application of biopsychosocial and health system assistance, characterized by education, clinical and nonclinical health facilitation, care coordination, patient navigation, and client/patient advocacy, to collaborating clients/patients and their clinicians is given by licensed and trained health professionals until disentangled and prioritized barriers to improvement from a comprehensive assessment have been reversed, health is stabilized, and maximum benefit has occurred".(Kathol. R. 2016)
Care coordination as defined by the Agency for Healthcare Research and Quality is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

34) ANSWER B:

A comprehensive neuropsychological assessment may be appropriate given the client's history of a motor vehicle accident. Whether identified at the time of emergent treatment or not, closed head injuries are often the result of a coup–contrecoup assault to the brain. Neuropsychological testing as performed by a trained clinician generally includes an evaluation of reasoning and problem solving; academic skills; visual-spatial organization and motor skills; emotions, personality, and behaviors; short- and long-term memory and attention; language; and planning and organization skills.

Although establishment of the level of cognitive function through utilization of a cognitive scale such as the Rancho Los Amigos might be helpful in establishing baseline status, a neuropsychological assessment may offer a more comprehensive understanding of client behavior and development of an individualized plan to advance rehabilitation goals.

35) ANSWER: D

In every testing situation, it is important to remember to choose the best or most correct response. In this instance, each response might be appropriate for different patients at different times, but the question asks which initial action of the case manager might be appropriate.
The Standards of Practice for Case Management as presented by the Case Management Society of America detail the case management process as a cyclic process of assessment, planning, coordination, implementation, monitoring, and evaluation. In assessing this situation, the case manager might wish to identify if a previous client encounter with a health care professional such as a primary care physician might have included the development of an advanced directive. Subsequent case management interventions may include both a referral to risk management or an ethics committee and facilitating a family discussion to seek resolution of the conflict.

36) ANSWER: B

Again, please remember that this question calls for the best or most correct response. As a case manager, my first step might include collaborating with the cardiac rehabilitation team. That team may be aware of alternative methods for reimbursement of services and might have experience with developing appropriate transportation for the client. If the recommended transitional care plan for outpatient cardiac rehabilitation services cannot be realized, other sites for the delivery of care might be considered including inpatient rehabilitation programs or home health care services that provide focused cardiac rehabilitation therapies.
Documentation is an essential element of the provision of case management interventions and the primary focus of documentation in this case might include the stated concerns of the client/family as well as the specific steps the case manager employed to advance the provision of cardiac rehabilitation in an environment that reflects the client's preference for care.

37) ANSWER: D

Ethnocentrism is a belief that your own cultural or ethnic group is superior to other cultural or ethnic groups. Xenocentrism is a preference for the foreign. It is the exact opposite of ethnocentrism. Essentialism is a belief that people and things have "natural" characteristics that are inherent and unchanging. Cultural essentialism is the practice of categorizing groups of people within a culture, or from other cultures, according to essential qualities.

38) ANSWER: A

Developed to facilitate the accurate sharing of a client's end-of-life wishes across all treatment environment and transitions of care, the Physician Order for Life-Sustaining Treatment provides a vehicle for the effective and efficient communication of a client's specific directives for end-of-life care. Five Wishes is a detailing of a client's directives regarding:

- Who will serve to make health care decisions for the client if the client is unable to make those decisions
- The type of medical care wanted or not wanted
- Desired comfort level
- Desire for how the client wishes to be treated
- Preference for information shared with family such as directive regarding funeral and/or memorial services

Neither the POLST or Five Wishes meet statuary requirements as legally binding advanced directives in all states.

39) ANSWER: B

Maladaptive families are typically unable to achieve a balance between meeting a client's needs and maintaining his or her own ability to function. These families are often considered to be inflexible, disengaged, chaotic, and unable to effectively communicate with each other. Dysfunctional families display characteristics such as frequent conflict especially heated conflict, unpredictability, potential for abuse and/or neglect, addictive behaviors, unrealistic expectations for family members, and a lack of empathy for other family members.

40) ANSWER: B

Change is often defined as a progress that includes multiple steps. The initial step in this process is precontemplation. In this step, the person who seeks or requires a change in behavior may not even recognize the need for change or may rebel against any mention of the need for change. Contemplation includes a realization that a problem may exist and change may be necessary. Clients may express ambivalence and may not have fully committed to initialing the steps necessary to advance that change or are stalled in the ability to either move toward change or continue unhealthy behaviors. Preparation or commitment to action is the stage in which the client has expressed willingness to a change in behavior within a specific period of time, which is generally 30 days. The next stage is implementation of an action plan to affect health behavior change. It may include external support in the form of therapies or support groups or tools and continues for a period of at least six months. The final stage of change is maintenance in which desired behaviors are sustained over time.

41) ANSWER: D

OARS is a mnemonic that represents basic interactive techniques for supporting clients in achieving health behavioral change. Based on motivational interviewing concepts in a manner that is client-specific and culturally appropriate, the four aspects of OARS include the use of open-ended questions, affirmation, reflective listening, and summaries in order to promote the desired change.

42) ANSWER: A

Kinetics is the interpretation of body language as a form of nonverbal communication. It includes facial expressions and gestures as well as other movements of the body that convey a message. Paralanguage is not the meaning conveyed in the spoken word but rather vocal quality, loudness, pitch, and tempo. Haptics is a nonverbal and nonvisual form of communication that is focused on messages delivered through the sense of touch. Chronemics is another form of nonverbal communication that is defined as the role time and time perception play in the communicative process. It is the manner in which one perceives and values time, structures time, and reacts to timeframes. Examples include promptness, a willingness to wait, and the length of time someone might be willing to participate in an educational process.

43) ANSWER: C

A process of validation and ventilation allows the person experiencing a crisis to express his or her perspective of the crisis in an environment that is nonjudgmental, confidential, and compassionate. When encouraging clients to talk about the crisis they are experiencing or have experienced, health care professionals should employ active listening skills and be cognizant of their body language, facial expressions, and tone of voice to avoid any perception of disapproval of the information presented.

44) ANSWER: D

Posttraumatic stress disorder as defined by the National Center for PTSD may include the following symptoms:

- Reexperiencing the traumatic event in the form of flashbacks or nightmares
- Avoiding situations that may trigger memories associated with the traumatic event
- Emotional numbness, avoidance of relationships, and fear of trusting others
- Increased arousal such as sleep disorders, compromised ability to concentrate, and being easily irritated and angered

Although feeling tense, having angry outbursts, or being unable to sleep may be signs of other behavioral health diagnoses, PTSD is most commonly associated with exposure and reaction to a traumatic event.

45) ANSWER: A

Self-neglect represents an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care. Signs of self-neglect might include:

- Unsanitary living environment and/or poor personal hygiene
- Signs of dehydration and/or malnutrition
- Disorganized and sometimes ignored finances including bill paying
- Diminished focus on health such as missed physician appointments and medication nonadherence

Although cognitive impairment and psychosis may contribute to self-neglect, the cause of self-neglect may be multifactorial.

46) ANSWER: D

Spirituality is often defined as the belief in a higher power that is greater than oneself or an intertwining of a personal belief regarding the meaning of life and an individual's beliefs regarding the path to achieving inner peace. Religion is considered to be a more formalized system of beliefs and practices that relates to a higher power.

47) ANSWER: A

The pathway to change often begins when a client considers a desired goal and the challenges associated with achieving that goal. Ambivalence is often described as the coexistence of opposing attitudes, beliefs, or feelings. A client that expresses a desire to change and highlights the barriers to that change is said to be ambivalent. A client who wishes to lose weight without reducing caloric intake is unable to move from indulgence to restraint and is an example of ambivalence. Change-talk is described as an expressed desire to seek and to commit to achieving health behavioral change rather than focusing on the steps necessary to affect that change.

48) ANSWER: D

Disease management has been defined by the Case Management Society of America (CMSA) as a "subset of case management in which health-related assistance, characterized by education, health facilitation, care coordination, and client/patient advocacy, is given to all collaborating clients/patients within a population who have one or more selected chronic health conditions by licensed and trained health professionals, usually nurses and social workers, with the goal of reversing barriers to improvement and stabilizing health by connecting client/patient assessment findings to a plan of care."

Patient navigation can be a form of disease management that employs a client-focused concept concentrating on the movement of a client throughout the health care continuum and across each transition of care. That said, not every form of patient navigation meets the CMSA definition referenced in this question.

Health coaching, as defined by the CMSA, is a process that assists clients who are at risk for development of health conditions or complications from existing conditions to understand (and implement) habits of healthy behavior.

49) ANSWER: D

Patient empowerment has been defined by the World Health Organization as "a process through which people gain greater control over decisions and actions affecting their health." Aspects of patient empowerment include self-efficacy, self-awareness, confidence, coping skills, and health literacy.

Patient engagement is active participation by a client and/or family in their own care with a goal of advancing the attaining of positive health care outcomes. Patient empowerment is often a component of strategies utilized to advance patient engagement.

50) ANSWER: B

Wellness has been defined not as a lack of illnesses but rather the presence of a life purpose, engaging in meaningful work and play, joyful relationships, a healthy body and living environment, and achieving happiness. Well-being is considered to be a dynamic process that offers a view of life status through the interaction among a person's circumstances, activities, and psychological resources. Well-being is an aspect of wellness.