Case Management: Across the Care Continuum

By

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Presented by CEUSchool
**Brief Bio**

**Jane Harkey** is a Professional Geriatric Care Manager with a private practice. She has developed and presented many post-graduate continuing education seminars at Rutgers University School of Social Work, Piscataway, New Jersey. She has also delivered numerous presentations at local, state and national conferences.

**Years of Experience:** 20+ as a Social Worker

**Academic Qualifications:**
- AA- RN
- BSW
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**Certifications:**
- Post- Graduate Certification in Gerontology
- Certification in Gerontological Nursing

**Brief Course Description:**
Case Management is a growing aspect of health care. This course will discuss:
- Why Case Management is evolving as an important part of the healthcare field
- What is Case Management
- Case Management Activities
- The Standards for Social Work Case Management
- Important Case Management Acronyms
- Legal aspects of case management
- The role of a Social Worker in Case Management
Writers Comments Regarding this Topic:
Due to the increase use of healthcare resources as a result of the rise in chronic illnesses and the aging of the population, case management as a care option will be used much more in the future. Individuals, caregivers, insurers and others will look for case managers to connect people with the care they need while avoiding unnecessary treatments. This provides a better quality of care for individuals while containing healthcare costs. Even more important, case managers can help individuals and/or their caregivers navigate through the complex healthcare system. This reduces frustration and improves the quality of life for the individuals and their caregivers. This course will help Social Workers learn the basics of case management and appreciate its value as a viable tool in the continuum of care.

Course Objectives:  
After completing this offering, the participant will be able to:

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<tr>
<td>1. Define case management</td>
<td>6. Identify the 10 NASW Standards for Social Work Case Management</td>
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<td>2. List the 6 primary activities of a case manager</td>
<td>7. List 3 types of information critical to the implementation process</td>
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<td>3. List 4 content areas needed in an assessment</td>
<td>8. List 2 methods to provide coordination of care</td>
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<td>4. List 6 issues that must be addressed in the planning process</td>
<td>9. Describe how documentation is used in the monitoring process</td>
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<td>5. Identify at least 5 acronyms a case manager should know</td>
<td>10. Discuss how evaluation is used in case management</td>
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<td>11. Define the goal of case management</td>
<td>12. List at least 5 roles of a Social Worker in case management</td>
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PART I: BACKGROUND

Case management, also known as care management, is perceived by many to be a relatively new concept in healthcare, but it has actually been used for over a hundred years. Originally developed and implemented by nurses to coordinate fragmented services and control costs, it has been used by social workers as a method to arrange and coordinate care since the earliest history of the social work profession. Today case management is practiced across the healthcare continuum, from acute-care hospitals to out-patient facilities, insurance companies and third-party providers. It is a core concept of social work practice.

Case management is a profession which helps individuals and/or their caregivers meet day-to-day and long-term care needs. It helps them to adjust and cope with the challenges of illness, disabilities and/or aging. Services which are provided include:

- Conduct care-planning assessments to identify problems and determine eligibility for assistance and the need for services.
- Screen, arrange and monitor in-home help or other services.
- Review financial, legal or medical issues and offer referrals to specialists to avoid future problems and conserve assets.
- Provide crisis intervention.
- Act as a liaison to families/caregivers living away from the individual, ensuring that things are going well and alerting them to problems.
- Assist with relocating individuals to the most appropriate and least restrictive setting.
• Provide education and advocacy.
• Provide counseling and support.

The services are custom tailored to meet the individual’s preferences and needs. The continuity of case management services helps to save time, stress and costs to the individual or caregiver. Ongoing monitoring of living and care requirements can often avoid unnecessary admissions to hospitals and development of crisis situations. It provides peace of mind to everyone involved in the care of an individual.

The terms “case manager” and “case management” have been used for over 20 years. However, these terms are still relatively new to most people. There is no universally accepted definition of case management, nor is there one definitive model of case management practiced within the social work profession.

A consumer-friendly definition of a case manager was developed by the Case Management Leadership Coalition. It states, “Case managers work with people to get the health care and other community services they need, when they need them and for the best value.”

The National Association of Social Workers (NASW) has a more detailed definition of case management. It states: “Social Work case management is a method of providing services whereby a professional social worker assesses the needs of the patient and the patient’s family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific patient’s needs. Social Work case management addresses both the individual patient’s biopsychosocial status as well as the state of the social system in which case management operates.”
Case management enhances access to care and improves the continuity and efficiency of services while respecting the autonomy of each person. It is a healthcare specialization that helps people and/or their caregivers meet day-to-day and long-term care needs by taking a holistic approach to assist them to adjust and deal with the challenges they face while trying to cope with their physical, social, psychological, cultural and spiritual needs. Case management is not a time-limited service, but is intended to be ongoing, providing people whatever they need, whenever they need it and for as long as necessary. It facilitates the person’s achievement of his or her optimum level of wellness, self-management and functional capability.
PART II:  CASE MANAGEMENT ACRONYMS

It is important for the case manager to be able to understand and communicate with all members of an interdisciplinary team. A case manager will be involved with many other healthcare professionals as well as insurance companies, third-party payers and health facilities’ administration. Each profession/organization has its own “lingo”. The medical profession is especially fond of acronyms. Following are some of the acronyms a case manager may encounter and should be familiar with:

- ADA  American Disabilities Act
- ADL  Activities of Daily Living
- ADRG  Adjacent Diagnosis Related Group
- AFDC  Aid to Families With Dependent Children
- BATNA  Best Alternative to a Negotiated Agreement
- BBA  Balanced Budget Act
- CAR/CARE  Concern, Action, Response, Evaluation
- CCM  Certified Case Manager
- CDH  Client Driven Healthcare
- CEA  Cost Effective Analysis
- CHAMPUS  Civilian Health & Medical Program of the Uniformed Services
- CM  Case Management/Case Manager
- CMC-A  Case Manager Associate
- CMS  Center for Medicare and Medicaid Services
- COB  Coordination of Benefits
- COBRA  Consolidated Omnibus Reconciliation Act
- C-SWCM  Certified Social Work Case Manager
- DAR/DARE  Diagnosis, Action, Response, Evaluation
- DC  Discharge
- DM  Disease Management
- DME  Durable Medical Equipment
- DNR  Do Not Resuscitate
- DRG  Diagnosis Related Group
- Dx  Diagnosis
- EMR  Electronic Medical Record
- EMTALA  Emergency Medical Treatment & Active Labor Act
- EOL  End of Life
- EPO  Exclusive Provider Organization
- ERISA  Employee Retirement Insurance Security Act
- FEHBP  Federal Employees Health Benefits Program
- FMLA  Family & Medical Leave Act
- FQHC  Federally Qualified Health Center
- HCP  Healthcare Professional
- HIPAA  Health Insurance Portability and Accountability Act
- HIPC  Health Insurance Purchasing Cooperative
- HIT  Health Information Technology
- HMO  Health Maintenance Organization
- Hx  History
- IADL  Instrumental Activities of Daily Living
- IC  Informed Consent
- IDS  Integrated Delivery Systems
- IME  Independent Medical Exam
- IPA  Independent Practice Association
- LTC  Long Term Care
- LTD  Long Term Disability
- MAPS  Multidisciplinary Action Plans
- MCO  Managed Care Organization
- MDS  Minimum Data Set
- MSA  Medical Savings Account
- OASIS  Outcome & Assessment Information Set
- OBQI  Outcome-Based Quality Improvement
- OHM  Office of Minority Health
- OTC  Over the Counter (Medicine)
- PBM  Pharmacy Benefits Management
- PHI  Protected Health Information
- PMH  Past Medical History
- POC  Plan of Care
- POS  Point of Service
- PPO  Preferred Provider Organization
- PPS  Prospective Payment System
Becoming familiar with these acronyms will improve understanding and communication within the interdisciplinary healthcare team and in the case manager’s documentation.
PART III: ACTIVITIES OF A CASE MANAGER

Given projections for increased use of healthcare resources due to the rise in chronic illnesses and the aging of the population, case managers will be utilized much more in the future. Individuals, families, care providers, insurers and others will look to case managers to help ensure that people have access to the right care at the right time, while avoiding unnecessary or duplicate treatment.

Trying to navigate through the complex healthcare system can be difficult for providers but is even more frustrating for family members. Locating and coordinating community and government services can be expensive or sometimes impossible for them. Case managers can assist them in this process.

Depending on the specific setting and locale, case managers are responsible for a variety of tasks, ranging from linking persons to services, to actually providing intensive clinical or rehabilitative services themselves. Other core functions include outreach to engage persons in services, assessing individual needs, arranging requisite support services (such as housing, benefit programs, job training, etc.), monitoring medication and use of services, and advocating for a person’s rights and entitlements. To better understand the tasks, it is important for social workers to understand the role of case managers and the aspects of case management.

All of the services a case manager provides can be categorized into six primary activities: Assessment, Planning, Implementation, Coordination, Monitoring, and Evaluation.
**Assessment:** Assessment is the process of collecting in-depth information about a person’s situation and functioning to identify individual needs in order to develop a comprehensive case management plan that will address those needs. There are many different types of assessment tools. The OASIS (Outcome & Assessment Information Set), for example, is used by home health agencies and the MDS (Minimum Data Set) is used by Long Term Care (LTC) Facilities. Whatever tool is used, it should be comprehensive and include at least the following:

- **Demographic Data:** Name; Address; Telephone Number; Date of Birth; Sex; Race; Religion; Emergency Contact Information; Physician Information; Veteran Status; Medicare/Medicaid Numbers (if applicable); Other Insurance/Payment Sources; Primary Language; Marital Status
- **Medical Data:** Past Medical History (PMH); Current Diagnoses (Dx), Conditions or Signs/Symptoms (SS); Allergies; Recent Hospitalizations/Reason for Admission; Treatments (Tx); Medications (include OTC medications); Diet; Prognosis; Review of Systems (ROS) including Vision, Hearing, Speech, Skin Integrity, Pain, Elimination/Incontinence, Cognitive, Behavioral, Nutrition
- **Functional Ability:** ADL (Bathing, Grooming, Dressing, Toileting, Transfer, Walking, Eating); IADL (Medication Management, Money Management, Transportation/Driving, Use of Telephone, Meal Preparation, Housekeeping, Laundry, Shopping/Errands); Equipment Management
- **Living Arrangements:** Current Residence; Structural Barriers; Safety Hazards; Sanitation Hazards; Residing With/Supportive Assistance; Environment (Inner City, Rural, etc.)
Many sources should be accessed to make a complete assessment. These may include the individual, family/caregivers, professional caregivers, employers, past medical records, military records and any other sources of information needed to get a complete picture of the individual’s status.

**ASSESSMENT**

- Demographic Data
- Medical Data
- Functional Ability
- Living Arrangements

**Planning:** Planning is the process of reviewing the data obtained during the assessment, identifying the person’s needs and developing a Plan of Care (POC) to meet those needs. During this process, many issues must be addressed:

- The capability, availability and willingness of the individual and/or the caretakers to provide or accept needed services. A Plan of Care could meet every need, but if the individual and/or caregivers find it unacceptable, they will ignore it. This especially occurs when it applies to cultural issues. This can lead to frustration for everyone and the individual may be viewed as non-compliant by the case manager. On the other hand, family members may want to meet the individual’s needs but the desire is unrealistic relative to their ability to do so.
• The financial resources available to access needed services (I.E.: insurance, Medicare or Medicaid, private pay, etc.). Again, the care plan can be comprehensive but if the individual/caregiver cannot afford the services, the care plan is useless.

• The safety needs in the current environment (I.E.: barriers, activity limitations, cognition of the individual, frailness of the individual, signs of abuse, etc.). Almost everyone wants to remain in their home, but if the environment is unsafe and cannot be made safe enough for the individual, a care plan for in-home retention is irrelevant and inappropriate.

• The availability of the needed resources (I.E.: waiting list for services of public benefit programs, no services available in rural areas, etc.). The identified needs must be addressed in a timely manner and a care plan that does not have readily available resources is not appropriate.

• Prioritizing the individual’s needs to best meet the available resource allocation (I.E.: limited amount of funds to pay for services, limited number of allowable treatments/days of service, etc.). Some individuals have too many needs for the available service or financial resources. The case manager must be able to prioritize the most imminent needs and routinely reassess and prioritize the needs to optimize the individual’s level of wellness and autonomy.

The Plan of Care (POC) is the document that defines the type and timeline of the care activities, the expected outcomes of care that each discipline involved in the care of the individual is responsible for and serves as the guide to evaluate the effectiveness and appropriateness of the care provided. There are many methods to develop a POC. One such method is using Clinical Pathways that identify uniform care for a given case type. Another type is MAPS
(Multidisciplinary Action Plan), where a plan of care is developed by an interdisciplinary team. Whatever the method used, the plan must be written in objective language with measurable outcomes that are assigned a specific timeline, including benchmarks, to be accomplished by. They should identify the problem, the goal for its resolution and the manner/plan in which the problem is to be resolved. For example:

Wrong:

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Plan</th>
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<tbody>
<tr>
<td>Pain</td>
<td>Mrs. X will be pain-free</td>
<td>Provide pain medication</td>
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Correct:

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Plan</th>
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<tr>
<td>Pain</td>
<td>Mrs. X will report pain levels no higher than 5 on the Numeric Pain</td>
<td>Pain evaluation will be conducted daily or PRN by the home health worker; pain medication will be administered as directed by the physician PRN</td>
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<td></td>
<td>Intensity Scale X30 days</td>
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The first example is subjective and not measurable, whereas the second example can be analyzed and measured to ensure Mrs. X will have adequate pain management and determine if the medication regimen the physician ordered is managing the pain.

Every Plan of Care must contain a Discharge Plan.
PLANNING

- Ability, willingness and acceptance of plan
- Available Financial Resources
- Available Service Resources
- Safety
- Prioritize Needs
- Documentation – objective, measurable, timeline
- Discharge

**Implementation**: Implementation is the process of executing specific case management activities and/or interventions that will lead to accomplishing the goals set forth in the Plan of Care. The case manager must be familiar with the resources that are available to the individual to implement the Plan of Care. He/she must understand the eligibility, benefits and structure of the potential resources. Examples of the type of information critical to the case manager are:

- **Financial Resources**: Managed Care, Medicare, Veterans Benefits, Medicaid, Medicaid Waiver Programs, Disability Benefits – LTD & STD, Private Health Insurance, Long Term Care (LTC) Insurance, Worker’s Compensation, Coordination of Benefits, Birthday Rule, PPS (Prospective Payment System), Car Insurance for Motor Vehicle Accidents, Hospice, MSA (Medical Savings Accounts), etc.

- **Community Service Resources**: Home Health Nursing, Aide, & Homemaker Services; Healthcare Delivery Systems (HMO, EPO, IPA, MCO, PPO, etc.); Meals on Wheels; Physical, Occupational, Speech, Vocational, & Rehabilitation Therapists; Acute Care Hospitals; Rehabilitation, Long Term Care, Skilled Nursing, & Mental Health Facilities;
Physicians; Nurses; Psychologists; Pharmacists; Play, Music, & Art Therapists; Bereavement, Substance Abuse, & Mental Health Counselors; Hospice & Palliative Care Centers; Chaplains & Religious Leaders; Social Workers; Discharge Planners; Volunteer Coordinators & Trained Volunteers; Other Case Managers; Recreation Centers; Infusion, Laboratory, & Respiratory Services; Agencies for Geriatrics, Hearing, Sight & Physical Disabilities; Organizations for Specific Diagnoses; Specific Centers or Camps for a Given Diagnosis; Services Specific to the Geographic Area the individual Lives In; Culturally Accepted Complementary & Alternative Care Providers (Acupuncture, Eastern Medicine, Chinese Medicine, Homeopathic Medicine, Meditation and Guided Imagery, Chiropractics, Herbal Medicine, Yoga, Tai Chi, Qigong, Massage Therapy, Craniosacral Therapy, Reiki Therapy, & Nutrition Based Therapy); etc.

- Legal Issues: HIPAA (Health Insurance Portability & Accountability Act), Proper Documentation, ADA (American Disability Act), DNR (Do Not Resuscitate) Orders, Living Will, HealthCare Proxy, Standards of Care, Informed Consent, Employee Retirement Insurance Security Act (ERISA), FMLA (Family & Medical Leave Act), COBRA (Consolidated Omnibus Reconciliation Act), TANF (Temporary Assistance for Needy Families), Non-Discrimination Laws, etc.

**IMPLEMENTATION**

- Financial Resources
- Community Service Resources
- Legal Issues
**Coordination**: Coordination is the process of organizing, securing, integrating and modifying the resources necessary to accomplish the goals set forth in the Plan of Care. To do this effectively, the case manager must know what services each resource is capable of providing. The case manager must also establish a network of providers for referral. The case manager must ensure that members of this network are appropriate to the need, provide services in a timely manner, are fiscally responsible, are reputable and are professional and ethical members of their discipline. The case manager can evaluate these qualities by noting their accreditation, the standards of care they follow (I.E.: Do they do background and criminal record checks on all employees), their governing body, representation on state boards, members of professional associations, member of Better Business Bureau, etc.

It is important to remember, for ethical conduct, to give each individual a choice of service providers and not recommend just one wherever possible. Also, an Informed Consent must be obtained prior to any service provision as well as a Release of Medical Information Form for each provider before any Protected Health Information (PHI) can be disclosed.

**COORDINATION**

- Develop Network of Providers
- Verify Provider Legitimacy and Professionalism
- Provide Multiple Choices
- Informed Consent/ Medical Information Release
**Monitoring:** Monitoring is the process of gathering information from all relevant sources about the status of the Plan of Care, thus enabling the case manager to determine the effectiveness of the plan. The most effective way to do this is through documentation. Every contact with an individual, caregiver, service provider and case manager must be documented (I.E.: Faxes, Telephone Calls, Reports, Interviews, Education/Information Provided, etc.). Non-compliance by the individual or caregiver should also be documented (I.E.: Refusal to adequately follow-up, no-show for appointments, reasons for non-compliance, etc.). Just as there is no single way to conduct an assessment and to write a Plan of Care, there is no single way to document the monitoring efforts. For example, some people document using the SOAP/SOAPE Method (Subjective, Objective, Assessment, Plan, Evaluation). Others use the DAR/DARE (Diagnosis, Action, Response, Evaluation) or CAR/CARE (Concern, Action, Response, Evaluation) style of documentation. Whatever method is used, legal issues must be observed for proper documentation.

- All documentation must be written in permanent ink or on a password-protected Electronic Medical Record (EMR).
- Documentation language must be objective in tone.
- Only use abbreviations that are standardized by the agency; beware of dual-meaning abbreviations (I.E.: BS = Blood Sugar or Bowel Sounds).
- Do not erase/obliterate/remove any entry. Use the SLIDE (Single-Line-Initial-Date-Error) method for hand-written documentation and add the correct information at the next available space. On electronic records, add the information at the next available space without changing the incorrect data.
• Always date and sign every entry in the Medical Record; never sign someone else’s entry.
• Write legibly to prevent misunderstandings by others who refer to the Medical Record.
• Never resort to “jousting” (Criticism of other health care providers written in the medical record); this can be critical in a claim of malpractice.
• Don’t write/document anything you wouldn’t want the individual/family/jury to see.
• Remember – in a court of law, “If it’s not documented, it’s not done”

The case manager may also be responsible for physically monitoring the service provision. For example, dropping by an individual’s home when a home health aide is present to verify that the appropriate care is being given. Again, any interaction must be documented.

**MONITORING**

• Written Permanently
• Objective Language
• Standardized Abbreviations
• Error Correction – SLIDE Method
• Date/Sign Every Entry
• Write Legibly
• Never “Joust”
**Evaluating:** Evaluation is the process of gathering and analyzing data about the service provision and comparing the effects of the interventions on the goals or objectives established in the care plan. The purpose of this process is to determine the efficiency and effectiveness of the care plan to meet the needs of the individual. This evaluation is on-going and should be done periodically or whenever the condition of the individual changes. Benchmarks to determine progress towards goal attainment must be part of the evaluation process.

To gather data, the care manager must know the contents of the assessment and the desired outcomes, monitor the service provision, be able to measure the outcomes and review the utilization of resources (UR).

To evaluate if a care plan is effective, the individual should demonstrate continuous improvement or resolution of the need. The case manager should compare the assessment data with the expected outcomes and determine if the goals were met and if the individual responded appropriately to the interventions performed. The evaluation should also determine if the care was suitable to the cultural and social needs of the individual.

To evaluate if the care plan is cost-effective, the care manager must ensure the proper level of care needed; know the cost of the care; and determine what, who, how much, and where is the available care. Using this information, the case manager can ensure that only necessary costs prevail. A Cost Effective Analysis (CEA) can be done to definitively determine the most economical care plan. This is a form of economic analysis that compares the relative expenditures (costs of the services) and outcomes (effects of the services) of two or more courses of action (implementations). This would determine the most cost-effective intervention.
If there are barriers to successful goal achievement, it is necessary to identify the barriers, resolve what needs to be done to overcome the barriers and incorporate these strategies into a revised plan of care. However, if the goals are unattainable due to the condition of the individual, a new plan of care must be developed.

**EVALUATION**

- Gather and analyze data relating to outcomes
- On-going
- Determine efficiency and effectiveness of the care plan
- Care plan culturally and socially suitable
- Cost effective
- Revise or rewrite as needed

These six primary activities of a case manager contain the core responsibilities of a social worker in the case management process.
PART IV: ROLES OF A CASE MANAGER

A social worker serves many roles in the case management system while fulfilling the six major activities of a case manager. A social worker performs in the role of:

- **Advocate**: The social worker always has the interests and needs of the individual foremost. The case manager advocates for the medical treatments and services necessary. This includes advocating with insurance companies, medical care and equipment providers, and any other person/organization when it is needed.

- **Provider**: The social worker performs in this role by selecting the most appropriate services for the individual; arranges for the services selected; seeks and obtains the most cost effective services; coordinates and tracks the services; reviews and evaluates the services; and follows-up with the individual and those involved in the provision of the services. The social worker may also be responsible for providing primary care.

- **Liaison**: The social worker communicates with others involved in the care of the individual to encourage mutual understanding and cooperation with members of the healthcare system; establishes and maintains a network of care providers; brings together and connects members of the health care system to obtain effective outcomes; focuses on the needs and probabilities for optimal outcomes at a reasonable cost; and considers the whole-life needs of the individual and the family.
• **Coordinator:** The case manager prioritizes and ranks the needs of the individual; designs a Plan of Care; expands the potential for successful outcomes by working with other team members.

• **Broker:** The case manager functions as the intermediary between two or more partners in negotiating agreements, arrangements and cost benefits; prevents and relieves potential issues of conflict; supports the best quality of life for the individual and the family; and expands care treatments where possible.

• **Educator:** The case manager empowers the individual and family by teaching them what they need to know about their health care. Some of the things the case manager instructs and teaches the individual and family about are the care and treatment of the conditions that necessitated the case management services; prevention strategies for safety issues; Informed Consent; health prevention such as nutrition, exercise, etc and end of life issues if appropriate.

• **Negotiator:** The case manager deals or bargains with others in the preparation of contracts; negotiates fees and costs; as well as assisting in deleting unfavorable clauses or adding benefits.
• **Evaluator:** The case manager appraises the value of services, equipment or supplies; determines the quality and results of the services; determines the most cost effective solutions and services; determines the best care plans and revisions for optimal outcomes; and evaluates alternatives, improvements and developments in the care of the individual.

• **Communicator:** The case manager conveys knowledge or information relating to healthcare issues to providers and the individual; communicates care and concern to the individual and the family; expands the individual’s ability to make an informed consent; expands the individual’s ability to determine his/her desired outcomes and get what is needed to reach the outcomes.

• **Risk Manager:** The case manager uses techniques to assess, minimize, and prevent accidents; uses proper documentation to increase knowledge to all healthcare team members to prevent medical errors and prevent duplicate or unnecessary treatments and assesses and attends to safety issues.

• **Mentor:** The case manager serves as a wise and trusted counselor or teacher to the individual and is an influential sponsor or supporter of the individual to others involved in the care of the individual.
• **Consultant:** The case manager gives professional or expert advice to others relating to the needs of the individual (I.E.: other care providers, insurance companies, etc.) as well as consulting with people and professionals throughout the healthcare system to provide the best quality of care possible.

• **Researcher:** The case manager provides diligent and systematic investigation into the care provision of the individual in order to discover or revise facts, applications and theories relating to the case management process to improve service. The case manager also seeks answers to questions relating to the healthcare needs of the individual.

• **Assessor:** The case manager makes assessments to determine optimal care plans; assesses the individual and matches providers throughout the healthcare delivery system to obtain optimal outcomes; analyses the individual’s strengths and areas in need of support; and assesses the family and social dynamics of the individual.

**ROLES OF CASE MANAGER**

• Advocate
• Provider
• Liaison
• Coordinator
These many roles enable a case manager to provide individual-centered care that is holistic, culturally appropriate, efficient, effective and cost-conscious.
Besides being accountable for the measurable outcomes contained in the Plan of Care, a social worker is also accountable to maintain professional standards of care. In 1992, the NASW developed and adopted ten Standards for Social Work Case Management:

1. The social work case manager shall have a baccalaureate or graduate degree from a social work program accredited by the Council on Social Work Education and shall possess the knowledge, skills, and experience necessary to competently perform case management activities.

2. The social work case manager shall use his or her professional skills and competence to serve the client whose interests are of primary concern.

3. The social work case manager shall ensure that clients are involved in all phases of case management practice to the greatest extent possible.

4. The social work case manager shall ensure the client’s right to privacy and ensure appropriate confidentiality when information about the client is released to others.

5. The social work case manager shall intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families.

6. The social work case manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services.

7. The social work case manager shall be knowledgeable about resource availability, service costs and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities.
8. The social work case manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager’s own case management services and to otherwise ensure full professional accountability.

9. The social work case manager shall carry a reasonable caseload that allows the case manager to effectively plan, provide, and evaluate case management tasks related to client and system interventions.

10. The social work case manager shall treat colleagues with courtesy and respect and strive to enhance interprofessional, intraprofessional and interagency cooperation on behalf of the client.

The Commission for Case Manager Certification has also issued eight principles in its Code of Professional Conduct for Case Managers. The code states:

1. Certificants will place the public interest above their own at all times.

2. Certificants will respect the rights and inherent dignity of all of their clients.

3. Certificants will always maintain objectivity in their relationships with clients.

4. Certificants will act with integrity in dealing with other professionals to facilitate their clients’ achieving maximum benefits.

5. Certificants will keep their competency at a level that ensures each of their clients will receive the benefit of services that are appropriate and consistent for the client’s conditions and circumstances.
6. Certificants will honor the integrity and respect the limitations placed on the use of the CCM (Certified Case Manager) designation.

7. Certificants will obey all laws and regulations.

8. Certificants will help maintain the integrity of the Code.

By following these standards and principles, as well as the NASW Code of Ethics, a social worker will be able to provide the highest quality of service and accountability during their case management activities.
Case management has been gaining more and more acceptance by providers and payers of healthcare as a result of spiraling medical costs. The reason for this is the comprehensiveness of the individual’s care when it is being case managed.

When individuals go to a particular physician, that physician rarely knows the complete past and present medical history of the person. To prevent a possible claim of malpractice, physicians want to “cover all the bases” and not be charged with failure to meet the standards of their profession by not prescribing what they feel may be necessary procedures or medications. On the other hand, quite often the individual does not fully understand everything that is being done and may not realize that a procedure has already been done or that medications prescribed by one physician may be contraindicated with medications prescribed by another physician. These instances can be not only costly monetarily, but can cause an adverse reaction resulting in a potential crisis situation necessitating even more expensive treatments to ameliorate the situation. Having an overview of an individual’s status and treatment can prevent something like that occurring.

More and more insurance programs, including Medicare and Medicaid, are encouraging or requiring case managed healthcare. This impetus will only increase in the future.

In the past, it was not mandated that case managers had to have specified training or certification. This is still the case. However, to insure quality of care, the movement is gaining momentum
toward mandating that anyone who wants to be classified as a professional care manager must be certified. There are several ways to do this:

- **CMC Certification (Care Manager Certified)** which requires passing an exam offered by the National Academy of Certified Care Managers (NACCM) and obtaining 45 contact hours of continuing education and a minimum of 1500 case manager working hours every three years. To get information: [www.naccm.net](http://www.naccm.net)

- **CCM Certification (Certified Case Manager)** which requires passing an exam offered by the Commission for Case Manager Certification and obtaining 80 contact hours of continuing education every five years. To get information: [www.ccmcertification.org](http://www.ccmcertification.org)

- **C-ASWCM Certification (Certified Advanced Social Worker in Case Management)** which requires a Masters level in Social Work, membership in NASW, and a current state exam-based social work license or a passing score on the ASWB exam. It also requires 20 contact hours of continuing education every two years. To get information: [www.socialworkers.org/credentials](http://www.socialworkers.org/credentials)

- **C-SWCM Certification (Certified Social Work Case Manager)** which requires a Bachelors level in Social Work, membership in NASW, and a current state exam-based social work license or a passing score on the ASWB exam. It also requires 20 contact hours of continuing education every two years. To get information: [www.socialworkers.org/credentials](http://www.socialworkers.org/credentials)

To ensure the legitimacy of the profession of case management, certification may be a requirement in the future for all social worker case managers.
Case management is a growing field of social work practice that encompasses the goal of supporting therapeutic relationships between providers and individuals. It strives to reduce and eliminate fragmented care, have appropriate resource utilization, have only necessary costs prevail, and empower the individual through education and mentoring. There are many models of case management utilized by various organizations/professions. However, they all have the same goal: Increased individual empowerment – decreased cost – increased effectiveness. They also focus all activities around the individual, respecting his/her autonomy.

Summary of the Key Points:

- There are six main activities of a case manager: Assessment, Planning, Implementation, Coordination, Monitoring, and Evaluation
- Assessment should include: Demographic Data, Medical Data, Functional Ability, Living Arrangements
- Planning involves: Willingness and acceptance of the care plan, available financial resources, available service resources, safety, prioritizing needs, documentation including a discharge plan
- Information critical for implementation: Financial Resources, Community Service Resources, Legal Issues
- For coordination, a case manager must: Develop a network of providers, verify provider legitimacy and professionalism, provide multiple choices, have Informed Consent and Medical Information Release
• To effectively monitor, the case manager’s documentation should: Be written permanently, use objective language, use standardized abbreviations, have errors corrected legally, be legible, not contain “jousting”, have all entries signed and dated

• Evaluation involves: Gathering and analyzing data on an ongoing basis, determining the efficiency and effectiveness of the care plan, having a culturally and socially acceptable care plan; being cost effective, being revised or rewritten as needed

• Roles of case manager: Advocate, Provider, Liaison, Coordinator, Broker, Educator, Negotiator, Evaluator, Communicator, Risk Manager, Mentor, Researcher, Assessor

• Case manager must conform to the NASW Standards for Social Work Case Management, the NASW Code of Ethics, Professional Standards of Care, and all laws & regulations; if the social worker is a Certified Case Manager, he/she must also abide by the CCMC Code of Professional Conduct for Case Managers

• The future of case management may require certification for all professional social work case managers
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