Standards of Practice & Scope of Services
for Hospital/Health System Case Management
Our Mission

To be THE Association
that offers solutions
to support the evolving
collaborative practice
of Hospital/Health System
Case Management.
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SCOPE OF SERVICES

PREFACE

Case management in hospitals and health systems represents a wide range of services and diverse methods of organizational structure. The concept of case management conveys different meanings to individuals and to organizations. The ACMA describes case management in the following context:

“Case Management in Hospital and Health Systems is a collaborative practice model including patients, nurses, social workers, physicians, other practitioners, caregivers and the community. The Case Management process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of Case Management include the achievement of optimal health, access to care and appropriate utilization of resources, balanced with the patient’s right to self-determination.”

Approved by ACMA Membership, November 2002

CONTEXT

In an effort to describe the varied functions that are considered Case Management Services, a Task Force was assembled to compile a collective of what ACMA considers to be the Scope of Services for Hospital and Health Systems Case Management. The Task Force elicited input from the ACMA membership and created a representative listing intended to describe and associate the vast nature of Case Management in various facilities throughout the country. The Scope of Services Task Force presents this list with the caveat that it is not intended as a “mandated” list of expected case management services for all to provide, but rather a compilation of case management services typically provided by hospital/health systems. The ACMA does not intend that this Scope of Services be a description of a Case
Management **Department's responsibilities.** ACMA recognizes that organizational structures frequently designate a **Service** as a **Department.** The ACMA Scope of Services represents the functions and responsibilities associated with the case management services that are provided to our patients. These services may be provided either primarily by case managers or secondarily by others. However, all are closely aligned with case management as defined by ACMA.

**The following categories best reflect this concept:**

- **Advocacy & Education**
- **Clinical Care Coordination/Facilitation**
- **Continuity/Transition Management**
- **Financial Management**
- **Performance & Outcomes Management**
- **Psychosocial Management**
- **Research & Practice Development**
- **Utilization Management**

**The following further describes the functions of each Service:**

**Advocacy & Education**

- Patient/Family Self Care Management
- Patient/Family Health Management Education
- Bioethics Referrals & Management
- Physician, Staff & Community Education
- Case Management Education & Training
- Risk Management Identification & Referral
- Legal Assistance/Coordination
- Customer Service/Guest Relations Management

**Clinical Care Coordination/Facilitation**

- Plan of Care & Outcomes Management
- Patient Care Integration
- Resource Management
- Patient/Family Care Conferences
- Interdisciplinary Care
  Communication/Coordination
- Continuity of Care Planning Management
SCOPE OF SERVICES

Continuity/Transition Management

• Capacity/Access Management & Throughput

• Discharge Planning
  — NH/SNF/Rehab/LTAC/Assisted Living Placement
  — Transportation & Travel Arrangements
  — DME
  — Home Health/Home Infusion
  — Mental Health Service Coordination

• Dialysis Coordination & Arrangements

• Pharmaceutical Authorization/Management

• Community Resource Coordination

• Advance Directives

• Palliative/End-of-Life Care
  — Hospice

Financial Management

• Health Care Resource Management/ Clinical Cost Efficiency

• Financial Assistance/Referrals

• Appeals Management

• Entitlement Program Coordination

• Patient Benefits Coordination: Medicare/Medicaid/SSI

Performance & Outcomes Management

• Federal/State/Local Regulatory Agency Compliance

• Joint Commission Standards Compliance

• Clinical Documentation Management

• Core Measures Utilization/Compliance

• Patient Safety Compliance

• Clinical Guidelines/Pathways/Evidenced Based Practice

• Quality Improvement Practice Standards
Performance & Outcomes Management (continued)

- Organizational Financial Performance/Management
  - Length of Stay
  - Cost per Case
  - Denial Management

Psychosocial Management

- Crisis Intervention
- Psychosocial Assessment/Functioning
- Counseling Support & Referral
- Abuse/Neglect Identification & Referral
  - Substance Abuse: ETOH/Drug
  - Adult/Child/Domestic/Elder
- Emotional Stability/Coping/Grief/Bereavement Support (Individual & Group)
- Adoption
- Health/Wellness Promotion

Research & Practice Development

- Clinical Practice Improvements
- Evidenced Based Clinical Practice
- Case Management Best Practice Standards Development
- Case Management Competency Development

Utilization Management

- Avoidable Delay Identification, Intervention & Tracking
- Utilization Review
  - Medical Necessity Review
  - Severity of Illness
  - Intensity of Service
- Pre-Admission Planning
- Third Party Payer Communication
- Level of Care Appropriateness Coordination
- Admission Status Determination
- Clinical Denial Prevention
A case manager works collaboratively with patients, nurses, social workers, physicians, other practitioners, caregivers and community resources and agencies. They are jointly accountable for measurable outcomes that are cost effective and reflect patient preferences and values.
STANDARDS OF PRACTICE

I. COLLABORATION

A case manager works collaboratively with patients, nurses, social workers, physicians, other practitioners, caregivers and community resources and agencies. The case manager and healthcare team are jointly accountable for measurable outcomes that are cost effective and reflect patient preferences and values.

The case manager:

• Respects the unique qualities, training, skill sets, interests and abilities of each person involved and works to eliminate duplication of efforts.
• Actively communicates with patient/family and all members of the healthcare team regarding the plan of care and progress towards goals.
• Works to ensure all stakeholders contribute to developing an effective plan of care.
• Creates safe and effective plans that are based on patient needs and preferences.
• Negotiates with payers regarding available options.

II. COMMUNICATION

A case manager communicates timely, relevant and accurate information to all parties involved with a patient’s care.

The case manager:

• Communicates in a manner appropriate to the stated preference, level of education and comprehension of the other party.
• Assures all communication is nonjudgmental and sensitive to cultural differences.
• Validates patient/family understanding of information.
• Assures informed decision-making through explanation of choices, risks and benefits to the patient, caregiver or healthcare team.
• Provides education that enhances patient/caregiver competence and capacity to participate in decision-making.
• Communicates in a judicious manner consistent with professional ethics, and with respect for patient/caregiver privacy and confidentiality.
• Chooses the appropriate time, venue and participants for optimal communication.
• Reveals any conflict of interest of his or her own or other parties’ that could influence the decision-making process.
• Chooses a tone, style and presentation that diffuses conflict.
• Maintains self-awareness regarding the influence of one’s own cultural background, values, and beliefs on working relationships.

III. FACILITATION
A case manager facilitates the progression of care by advancing the care plan to achieve desired outcomes.  
*The case manager:*  
• Facilitates the development of a safe and effective plan of care through early identification and thorough assessment of the patient’s needs and the resources available.
• Assures the designation of primary responsibility among the team members for each aspect of the plan, avoiding duplication and fragmentation.
• Carries out individual responsibilities according to the plan.
• Monitors progress toward the goals of the plan and makes revisions in response to changes in patient needs and condition.
• Proactively identifies and removes barriers that impede the progression of care.
• Refers facets of the care plan beyond the control or influence of the team to the appropriate level of authority.
• Fosters the team’s ability to work together and achieve desired outcomes.
• Utilizes Ethics Committee and other resources to resolve conflict or challenges regarding treatment decisions, if they occur.

IV. COORDINATION
A case manager integrates the work of the healthcare team by coordinating resources and services necessary to accomplish agreed-upon goals.  
*The case manager:*  
• Evaluates the patient’s/caregiver’s level of understanding and comfort with the progress towards goals.
• Utilizes the strengths and expertise of all team members to develop and implement the plan.
• Integrates services among community agencies, physicians, patient/caregivers, and others involved in the plan of care.
• Assures appropriate sequencing of all interventions for optimal results and smooth transition along the continuum.
• Identifies multidimensional (physiological, psychological, social and spiritual) factors and integrates into an individualized and holistic plan of care to attain expected outcomes.
• Elicits and incorporates the expectations of patients, physicians, healthcare team members and payers in the planning process.

V. ADVOCACY

A case manager advocates on behalf of patients and caregivers for service access or creation, and for the protection of the patient’s health, safety and rights.

The case manager:
• Promotes the patient’s self-determination in all decisions, honoring that right even when decisions differ from recommendations of the healthcare team, and assists the healthcare team’s understanding of and respect for the patient’s decisions.
• Assures patient receives information on benefits, risks, costs and treatment alternatives including the option of no treatment.
• Advocates for culturally competent care.
• Supports optimal health for at-risk persons through prevention, health promotion and education for populations with specific and unique health needs.
• Partners with community agencies to address unmet needs.
• Provides patient/caregiver education regarding the payment denial and appeal process.
• Recognizes limitations of a patient’s autonomy, preventing imminent danger to the patient or others.
• Participates in the evaluation and monitoring of the quality and effectiveness of continuing care services such as nursing homes, home care agencies and other agencies providing care to patients.
• Engages in legislative and professional activities.
VI. RESOURCE MANAGEMENT

A case manager assures prudent utilization of all resources (fiscal, human, environmental, equipment and services) by evaluating the options available and balancing cost and quality to assure the optimal clinical and financial outcomes.

*The case manager:*

- Evaluates cost of care with the benefits of patient safety, clinical quality, risk and patient satisfaction to provide recommendations and decisions that assure optimal outcomes.
- Educates patients/families on the economic impact of their healthcare choices.
- Assures timely progression to appropriate levels of care.
- Collects, analyzes and interprets data to identify practice patterns that may require modification.
- Maintains current knowledge of healthcare economics, trends and reimbursement methodologies and applies this knowledge to daily practice.
- Identifies and implements strategies for avoiding and/or managing unnecessary costs.
- Recognizes situations that require referral to Quality or Risk Management and makes a timely referral.
- Manages patient and caregiver expectations for short and long-term goals based on health status, prognosis and available resources.

VII. ACCOUNTABILITY

A case manager accepts responsibility and accountability for achievement of optimal outcomes within their scope of practice.

*The case manager:*

- Recognizes and respects that joint responsibility and joint accountability is inherent in collaborative practice.
- Follows through on his/her own commitments and expects others to follow through on their commitments.
- Utilizes best practice methodologies to improve care delivery.
- Contributes to decision-making and decision support as a member of the interdisciplinary team.
- Assures timely follow-up and evaluation of the care plan and implements changes as indicated.
- Maintains an ongoing awareness of his or her own competencies, seeking consultation and collaboration as needed.
VIII. PROFESSIONALISM

A case manager acquires and maintains knowledge and competence related to the expectations of their position and practices within their scope.

The case manager:

• Aligns practice with the mission, vision and goals of their employer.
• Maintains appropriate licensure and certifications.
• Commits to continuous learning and strives to improve competence in all areas of practice.
• Advances knowledge of the profession through research and application of best practice.
• Participates in patient safety and quality improvement activities.
• Participates in the orientation and training of students, interns, and new department members.
• Adheres to professional standards of practice and his or her professional code of ethics.
• Demonstrates commitment, initiative, integrity and flexibility.
• Regularly evaluates his or her own performance and sets goals for personal and professional development.
Supporting the Practice of Hospital Case Management...

ACMA strives to support hospital case managers by providing:

- NETWORKING
- EDUCATION
- PUBLICATIONS
- BENCHMARKING & RESEARCH

For more information or to join ACMA, visit www.acmaweb.org