Standards of Practice & Scope of Services
for Health Care Delivery System
Case Management and Transitions of Care (TOC) Professionals
OUR MISSION

To be THE Association for Health Care Delivery System Case Management and Transitions of Care (TOC) Professionals

©2013 by American Case Management Association
Little Rock, AR

All rights reserved. No part of this book may be reproduced in any fashion or by any means without written permission from ACMA.

Print copies are available for purchase online:
www.acmaweb.org/Standards
## SCOPE OF SERVICES

- Education: 3
- Care Coordination: 4
- Compliance: 5
- Transition Management: 5-6
- Utilization Management: 6-8

## STANDARDS OF PRACTICE

- Accountability: 9
- Professionalism: 9-10
- Collaboration: 10
- Care Coordination: 10-11
- Advocacy: 11
- Resource Management: 13
- Certification: 13-14
- Glossary: 14-16
SCOPE OF SERVICES

PREFACE

Case management in hospitals and health care delivery 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. ACMA describes case management in the following context:

“Case Management in hospital and health care 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 Health Care Delivery System Case Management. The task force solicited input from ACMA members 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 health care delivery systems. 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:

- Education
- Care Coordination
- Compliance
- Transition Management
- Utilization Management

The following further describes the functions of each Service:

**Education**

- For all patients requiring active case management services, case management is expected to ensure and provide education relevant to the effective progression of care, appropriate level of care and safe patient transition.

  **Specifically:**
  - Ensure that education regarding the injury/clinical/disease process has been provided by the health care team
  - Provide information to the health care team, patient/family/caregiver regarding available resources and benefits for acute and post acute services that ensures patient choice and a safe and timely transition
  - Identify clinical, psychosocial and/or operational learning opportunities that negatively affect care or reimbursement and provide the health care team, community partners, patient/family/caregivers education that will address or resolve the issues
Care Coordination

Case management is expected to have a defined method for screening/identification and assessment of patients in need of case management services. Additionally, case management must have defined standards for ongoing monitoring and interventions that advance the progression of care and must include the clinical, psychosocial, financial and operational aspects of care.

Screening/Identification

Case management will screen all patients for clinical, psychosocial, financial and operational factors that may affect the progression of care and through the use of identification criteria stratify patients at risk/barriers/strengths or in need of case management services.

Assessment

Case management must have a defined case management assessment tool that expands the case managers’ knowledge of the risks identified in the screening process and is complementary to the assessment of other clinical disciplines.

Plan of Care

Case management will review and ensure the plan is clinically appropriate and matches the patient’s care needs and is consistent with patient choice and available resources.

Sequencing

Case management will help ensure consults, testing and procedures are sequenced in a manner that is appropriate to the patient’s clinical condition and supports timely and efficient care delivery. Case management will actively intervene and resolve/escalate where barriers to service exist.

Communication

Communication both verbal and written is the foundation on which knowledge transfers, and collaboration and relationship building is based.
• Case management organizational structure and staffing, policies and procedures must meet the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation

• Case management is responsible for documenting information that is not duplicative but instead is complementary and contributes to the progression of care

**Compliance**

• Case management will be knowledgeable of and ensure compliance with the federal, state, local hospital and accreditation requirements that impact their scope of services.

• Case management organizational structure and staffing, policies and procedures must meet the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation

• All disciplines practice within the scope of practice as defined by state licensing regulations

**Transition Management**

• Based on the health care team’s assessment and patient choice and available resources, the case manager is expected to integrate these key elements and develop and coordinate a successful transition plan. Transition management planning begins at the time of case management’s initial patient encounter (preadmission, admission, emergency department, etc.) and is reevaluated and adjusted throughout the patient’s hospital stay

**Transition Coordination – Identification**

• Based on assessment, case management will identify patients with post-acute needs including those at risk for readmission and prioritize as well as intervene as needed

• For those patients at risk for readmission, case management will apply interventions to proactively prevent readmissions and evaluate those who are readmitted to identify and implement strategies for improvement
Community Partnerships

- Case management will identify available community resources/potential partners and advocate for resolution of gaps in the available resources and processes.
- Case managers will be knowledgeable of and provide available information for patients to make an informed choice regarding resources/providers.

Transition Coordination

- Case management will arrange/ensure all elements of the transition plan are implemented and communicated to key stakeholders including, but not limited to, the health care team, patient/family/caregiver, and post-acute providers.
- Case management will convey all necessary information for continuity of care and patient safety, verify receipt and provide a venue for additional questions and/or information requests/needs.

Follow-Up

- Case management will provide electronic, telephone, in person method of contacting the patient/family to validate the success of the transitional care plan within 72 hours.

Utilization Management

- Case management is expected to advocate for the patient while balancing the responsibility of stewardship for their organization and in general, the judicial management of resources.

Medical Necessity

- Case management will have a defined method to ensure the patient is in the appropriate “status” and level of care for the patient’s clinical condition. The process must include a method for secondary physician review when warranted.
Payer Interface

- Case management with respect to payer requirements will ensure timely notification and communication of pertinent clinical data to support admission, clinical condition, continued stay and authorization of post-acute services. When a lack of concurrence exists between the patient's needs and the payer's authorization, Case management will advocate securing reimbursement/resources needed for patient care. When no payer authorization requirements exist, case management accepts the role as a patient and organizational advocate to manage the utilization of resources.

Avoidable Delays/Days

- Case management will utilize a validated system/defined methodology for tracking avoidable delays/days and use this information to identify and communicate opportunities for improvement. Case management will participate in the development of performance improvement activities relevant to identified opportunities.

Denials/Appeals

- Case management will proactively prevent medical necessity denials by providing education to physicians, staff and patients, interfacing with payers and documenting relevant information.
- Case management will provide the clinical information necessary for the appeals process of cases for which medical necessity denial has been received.
- Case management will utilize escalation process as needed.
Case management in hospitals and health care delivery systems represents a wide range of services and diverse methods of organizational structure.
STANDARDS OF PRACTICE

I. ACCOUNTABILITY

Accountability is ownership for the achievement of optimal outcomes within their standards of practice. *The case manager:*

- Recognizes and demonstrates shared accountability, both at the individual and the team levels, that joint responsibility and joint accountability is inherent in collaborative practice
- Follows through on his/her own commitments and expects/prompt others to follow through on their commitments
- Contributes to decision-making and decision support as a member of the interdisciplinary team
- Ensures timely sequencing through the case management encounter

II. PROFESSIONALISM

A professional case manager emulates the standards of practice of case managers, their professional disciplines and the mission vision and values of their organization. *The case manager:*

- Aligns practice with the mission, vision and values of their health care organization
- Emulates the standards of practice for both case management and their professional discipline
- Maintains appropriate licensure and certifications
- Commits to lifelong learning and strives to improve competence in all areas of practice
- Advances the application of research and evidence-based practices
- Participates in the orientation and training of students and new department members
- Demonstrates commitment, initiative, integrity and flexibility
- Regularly evaluates his or her own performance and sets goals for personal and professional development
- Maintains current knowledge of health care economics, trends and reimbursement methodologies and applies this knowledge to daily practice
- Utilizes data to drive performance improvement
• Maintains current knowledge of health care economics, trends, and reimbursement methodologies and applies this knowledge to daily practice. Accepts responsibility as financial steward

III. COLLABORATION

Collaboration is working with patients/families/caregivers and the health care team to jointly communicate, problem solve and share accountability for optimal outcomes. These outcomes respect patient preferences and their available resources.

*The case manager:*
• Respects and values the contribution of all disciplines
• Communicates and collaborates with patients/families/caregivers and members of the health care team
• Builds and maintains relationships that foster trust and confidence

IV. CARE COORDINATION

A case manager facilitates the progression of care by advancing the care plan to achieve desired outcomes and integrates the work of the health care team by coordinating resources and services necessary to accomplish agreed-upon goals.

*The case manager:*
• Ensures 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 ensures revisions in response to changes in patient needs and condition
• Proactively identifies, communicates and resolves barriers that impede the progression of care
• Utilizes an organizationally defined escalation process to refer facets of the care plan beyond the control or influence of the team
• Evaluates the patient’s/caregiver’s level of
understanding and comfort with the progress towards goals and incorporates findings into the plan of care
• Arranges services among community agencies, physicians, patient/family/caregivers, and others involved in the plan of care
• Ensures timely sequencing of interventions for optimal results and smooth transition along the continuum
• Identifies clinical, psychosocial and/or spiritual needs and addresses/Refers to attain expected outcomes
• Elicits and incorporates the realistic expectations of patients/family/caregiver health care team members and payers in the planning process
• Identifies barriers to achieving recommended goals identified in the plan of care

V. ADVOCACY
Advocacy is the act of supporting or recommending on behalf of patients/family/caregivers and the hospital for service access or creation, and for the protection of the patient’s health, safety and rights.

The case manager:
• Identifies the legal decision maker (patient or surrogate)
• Ensures patient or surrogate receives information on benefits, risks, costs and treatment alternatives including the option of no treatment
• Promotes the patient’s self-determination in all decisions and assists the health care team’s understanding of and respect for the patient’s or surrogate’s choice
• Promotes culturally competent care
• Partners with payers to ensure the patient can access their full benefits and negotiates for benefit exceptions as needed
• Provides patient/family/caregivers available tools/resources to make informed choices
• Demonstrates the ability to balance resources with patient preferences
• Ensure that suspected cases of abuse, neglect or exploitation have been referred to the appropriate individual and/or agencies
• Utilizes the ethics committee or other resource to resolve conflict or challenges regarding patient care.
• Promotes the understanding and use of advanced directives and ensures patient wishes are respected
VI. Resource Management

Resource management assures prudent utilization of all resources (fiscal, human, environmental, equipment and services) by evaluating the resources available to the patient and balancing cost and quality to ensure 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 ensure optimal outcomes
- Educates patients/families/caregivers and health care team on the economic impact of their care options
- Facilitates timely progression to the appropriate level of care
- Identify and address avoidable delay practice patterns that may require modification to support cost-effective care. Uses escalation process as needed
- Identifies and implements strategies for avoiding and/or managing unnecessary costs that impact hospital
- Applies knowledge of hospital contractual arrangements to daily practice
- Secures the appropriate payer authorization to advance the plan of care
- Ensures appropriate medical necessity and manages under and over utilization
- Maintains awareness and complies with all regulatory requirements
- Recognizes situations that require referral to quality or risk management and makes a timely referral
- Manages patient/family/caregiver expectations for short- and long-term goals based on health status, prognosis and available resources

VII. Certification

Certification validates a case manager’s knowledge, competency and skills. Case managers holding an Accredited Case Manager™ (ACM) credential have proven that they are especially equipped to provide case management services within a health care delivery system.

ACMA Position Statement (Approved on December 2, 2016)

- Nurses and Social Workers with 36 months of health delivery system experience should have their Accredited Case Manager credential, ACM, to practice Health Delivery System Case Management. ACM exam eligibility requires a minimum of twelve (12) months of Health System Case Management experience.
GLOSSARY

Assessment
The identification and documentation of the patient’s initial transitional care needs within 24 hours of admission for the following elements:

- Medical necessity for patient status and level of care
- Psychosocial needs
- Clinical needs
- Anticipated discharge needs
- Spiritual needs
- Patient/family/caregiver health care level of understanding

And the amalgamation of the key elements into an initial transitional care plan with alternatives.

Care Coordination
Process whereby assessment, planning and interventions effectively integrate, ensure and advance the plan of care to support successful transitions.

Clinical Intervention
An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.

Intervention
- Carries out individual interventions
- Communicates and resolves barriers
- Utilizes escalation process as needed
- Provide the necessary elements of clinical and psychosocial information that minimize the potential for readmission
- Implement and continually modify as needed the transitional care plan
- Provide clinical and psychosocial interventions as needed
- Ensure and reinforces proactive patient/family/caregiver education

Live Follow Up
Electronic, telephone, in person method of contacting the patient/family/caregiver to validate the success of the transitional care plan typically within 72 hours.
Monitoring

- The act of reassessing minimally every 48 hours
- Utilizing a high risk stratification system, ensure a post-discharge live follow-up within in 72 hours for all identified patients

Planning

- Assures designation
- Ensures timely sequencing
- Elicits and incorporates elements necessary for transitional plan of care
- Develops the transitional care plan, incorporating patient's short and long term goals

Professionalism

Consistently demonstrates behaviors that result in credibility and respect for the individual and the case management practice.

Psychosocial Intervention

Assesses & intervenes to address psychosocial issues associated with hospitalization & transition plans.

- Assesses & intervenes, focusing on emotional/coping style, identification of patient/family resources and obstacles for complex psychosocial situations
- Utilizes clinical skill and expertise to provide assessment, intervention, and where appropriate, reporting for complex abuse, neglect, domestic violence and sexual assault situations
- Provides clinical social work assessment and intervention for complex crisis, mental health, substance abuse, adjustment and grief/loss situations
- Provides specialized knowledge and expertise for complex resource and benefit situations
• Assists other team members to understand and appreciate a patient and/or family’s reaction to a serious illness, injury, and/or chronic illness/disease as well as family and other environmental dynamics affecting care, treatment and compliance

• May develop and facilitate support groups

Reassessment
Ongoing reviews for medical necessity and adjustments to the transitional care plan as needed and minimally within every 48 hours.

Resource Management
Balances cost and quality through the effective evaluation and utilization of fiscal, human environmental, equipment and service options available to the patient.

Transitional Care Plan
The plan to move the patient along the care continuum including preadmission inpatient post acute and community.
Supporting the practice of health care delivery system case management...

ACMA strives to support health care delivery system case management and transitions of care professionals by providing:

NETWORKING  
EDUCATION  
PUBLICATIONS  
BENCHMARKING & RESEARCH

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