National Association of
Case Management

CASE MANAGEMENT PRACTICE STANDARDS

National Association of Case Management
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I. OVERVIEW

This document outlines the broad assumptions/premises, concepts, and principles/values which serve as the foundation for the practice of Case Management (CM) in a variety of settings and with multiple names that apply to case management. Case Management is the comprehensive term used. These ideas and ideals are actualized in the practice of case management when applied in conjunction with the implementation of fundamental functions, critical elements, and integrative qualities within a structured service delivery process for persons served by case management. More specifically, this document delineates standards for the practice of Case Management by trained, professional Case Managers:

1) Purpose of Case Management (Section II)

2) Definition of Case Management (Section III)

3) Persons Served by Case Management (Section IV)

4) Principles of Case Management (Section V)

5) Fundamental Functions of Case Management (Section VI)

6) Critical Elements (Section VII)

7) Service Delivery Process (Section VIII)

8) Integrative Qualities (Section IX)

II. PURPOSE of CASE MANAGEMENT

The purpose of case management is as follows:

1) To recognize the rights of individuals to professional and effective case management services.

2) To provide assistance and hope to individuals, their families, other supports and networks as defined by the individual.

3) To effectively and efficiently use services to promote wellness-based outcomes, identify strengths and abilities, needs, preferences, and goals within the process of service delivery.

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4) To support individuals toward maximizing the quality of life and achieving the most inter-dependent and fulfilling lives possible within their communities.

This is achieved through the implementation of the NACM Practice Standards and the professional Case Manager's adherence to ethical practice and professional conduct pursuant to the NACM Code of Ethics.

III. DEFINITION of CASE MANAGEMENT

NACM defines Case Management as **a coordinated approach implemented by professionals for the delivery of health, substance abuse, mental health, and social services, linking individuals with appropriate services to address specific individual needs and achieve stated goals**. This is the inclusive and broad spectrum definition that is used as a basis of the NACM Case Management Practice Standards for the profession of Case Management.

Historically, the term Case Management (CM) has been used in referring to various actions such as linkage and coordination activities. Other functions, with increasing responsibilities, have been added as CM models evolved. The development of helpful relationships and crisis prevention and intervention, resource management, sourcing supports, coordinating integrated care are now widely accepted CM functions, as are symptom management and skills development in the more intensive CM approaches. More recently, the term CM has been used to refer to a specific service and, ultimately, a profession. For the purpose of these standards, a contemporary definition is presented which builds on early descriptions of CM in terms of functions, but also incorporates some of the most important and recently-evolved principles within the context of a clinical process.

While there is validity of the argument that the use of the term Case Manager is outdated and implies that individuals are being managed, the term Case Manager continues to be an internationally accepted title to identify individuals who engage in the role or function of facilitating the case management process. In the United States, Canada, Australia, New Zealand, and elsewhere the position or job title of an individual providing the role of case management will differ between companies or agencies. NACM identifies a professional Case Manager by their role and function and not solely by their title.

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IV. PERSONS SERVED by CASE MANAGEMENT

Given that case management is provided across a variety of populations and ages including, but not limited to, individuals employed in case management roles within academia, health, integrated care, education, research, insurance, welfare, criminal justice, social and human service settings, private practice, and regulatory, accreditation, and payer entities, there is a need for consistency and clarity in articulating a description of persons served by Case Management.

These standards have been designed to be applicable across any/all populations in terms of age and presenting problems/concerns, needs, symptoms, disability, and/or desired outcomes.

V. PRINCIPLES of CASE MANAGEMENT

The principles associated with CM are as important as the definition and functions. More specifically, professional CM services should be:

1) Accountable
2) Consistent with restoring, maintaining, and enhancing well-being
3) Culturally sensitive
4) Effective in accomplishing outcomes
5) Empowering
6) Flexible and responsive
7) Individualized based on self-determination and choice
8) Informational
9) Trauma informed
10) Person-centered and network-inclusive
11) Provided to minimize risk of harm

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12) Strength-based

VI. FUNDAMENTAL FUNCTIONS of CASE MANAGEMENT

The fundamental functions of professional CM include, but are not limited to, the processes of:

1) Screening
2) Engagement and development of a helpful, trusting relationship/partnership
3) Assessment based on determining strengths, needs, preferences, and resources
4) Outcome-focused service planning and implementation (care coordination)
5) Crisis prevention, intervention, and management
6) Referral and linkage with chosen services
7) Obtaining basic and other supports as necessary and/or helpful
8) Monitoring, coordinating, and adjusting service delivery
9) Advocacy
10) Evaluation

VII. CRITICAL ELEMENTS

The critical elements of CM include:

1) Conceptualization (as part of the assessment/service planning process)
2) Continuity of Care/Transition Planning
3) Exploring and Resolving Ambivalence, Increasing Motivation, and Obtaining Commitment
4) Skill Development and Training
5) Individual Choice, Empowerment, and Informed Consent
6) Being Mobile and Offering Outreach in Least Restrictive Settings

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7) Frequency/Intensity of Services as Based on Need

8) Family and Kindred Support

9) Collaboration with Other Service Providers

10) Legal Context

11) Discharge/Closure

12) Documentation

VIII. SERVICE DELIVERY PROCESS

The service delivery process is informed by the fundamental functions and critical elements. These elements serve as the vehicle by which both principles and fundamental functions are operationalized. The articulation of these elements is furthered as these functions and principles are applied in a more concrete and practical manner. This often occurs in the context of conformance to the standards of regulatory, accreditation, and payer entities. Descriptions of these critical elements and fundamental functions are offered below in the context of a structured service delivery process.

This process is comprised of critical elements and fundamental functions which

- are completed across time;
- applied repeatedly within portions of; and
- across the entirety of, the course of an episode of service delivery.

All of the components are:

- necessary and important;
- depend and build upon one another; and
- concur and/or require the recurrence of another component.

1) SCREENING

This fundamental function addresses the need to determine eligibility and appropriateness for services. Specific parameters for eligibility can vary greatly as determined by particular

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regulations, accrediting bodies, payers, providers of service. Eligibility can be established formally or informally, with or without the use of specific tools.

2) ENGAGEMENT and DEVELOPMENT of a PARTNERSHIP

This component consists of several key tasks to establish:

a) Rapport: Establishing a professional relationship which is safe, trusting, and collaborative

b) Mutual Expectations regarding:

   i) Purpose of services

   ii) Nature of services

   iii) Roles/Boundaries (of/between all persons involved in the delivery of services)

   iv) Outcomes

These tasks are facilitated by active, specific, and deliberate service planning.

3) ASSESSMENT, CONCEPTUALIZATION, and SERVICE PLANNING

Assumptions

Service planning is most effective when completed in a holistic, comprehensive, and outcome-oriented manner. This approach incorporates several key elements:

a) Individualization

   i) Is directed at assisting the individual to achieve regular progress towards self-determined wellness-based goals.

   ii) Addresses the individual's/family's history and present life situation in a manner which is future- and goal-oriented, avoids blame, and works from strengths toward improved self-sufficiency and independence.

b) Regular Review of Progress and Revision of the Plan

   i) Is completed by the individual/family and Case Manager, and includes other service providers and significant others as necessary and beneficial

   ii) Is revised in the plan being based on experiences or changes in terms of progress, needs, and preferences

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iii) Is updated when indicated (as above) or according to policy and regulation

Assessment

a) Begins by collecting data from the individual and network as relative to issues identified in the referral and the domains of biopsychosocial information as described below:

b) Considers biopsychosocial history, data, or evaluation obtained through sources other than the individual, including standardized assessment tools when useful.

c) Addresses issues Identified in the referral and screening

d) Is thorough, complete, and ongoing.

e) Is Holistic - addresses the various domains of the individual's/family's life, including, but not limited to:

    i) Basic needs, including living/housing situation, activities of daily living and mobility

    ii) Family and natural supports

    iii) Crisis/safety (risk of harm)

    iv) Behavioral health, including trauma

    v) Intellectual or other developmental issues

    vi) Physical health

    vii) Alcohol and other drug use

    viii) Social, recreational, leisure

    ix) Financial, Insurance

    x) Legal, criminal

    xi) Educational, vocational

    xii) Cultural, spiritual

    xiii) Other human services system involvement

    xiv) Level of functioning

f) <u>Considers Strengths, Needs, and Preferences</u>

    i) <u>Strengths/Resources</u> – Skills, abilities, and/or useful resources/supports, activities, or services the individual has already established, as identified by the individual/family and/or Case Manager

    ii) <u>Needs</u> – A negotiated process to identify deficits, problems, barriers, and/or resources/supports or skills which are lacking

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iii) Preferences – Desired or preferred activities, situations, services, skills, and/or other resources/supports

iv) Maximizing strengths and following preferences is usually more effective and motivating than cataloging deficits and problems. An individualized strengths and preferences assessment that is related to the services a person needs to reach personal goals is likely to be more accurate and helpful than, or a critical supplement to, information gleaned from standardized functional assessments.

Conceptualization

a) Considers the bio-psycho-social data in a form which…

i) Provides a concise and focused “snapshot” of the individual

ii) Is thorough and complete

iii) Addresses and prioritizes primary problems, needs, or desired changes

iv) Addresses and prioritizes primary strengths, abilities, and skills

v) Addresses and prioritizes other significant barriers, influences, or issues impacting readiness for, or engagement in, change

vi) Addresses preferences

vii) Describes cautions

Outcome-Focused Service Planning

a) Goals/Outcomes and Objectives/Activities

i) Development of Goals as Concrete, Measureable Outcome Statements

ii) Goals/objectives are based on the results of the assessment

iii) Goals/objectives are based on the input of the individual

iv) Consideration of goals begins with the individual’s/family’s statement of their desired outcome in their own language, as developed through discussion into a concrete, measureable, outcome statement with specific targeted date of completion

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b) Development of Objectives/Activities as:

   i) Concrete and measureable

   ii) Specific in terms of timeframes, frequency, and duration

   iii) Manageable/achievable for the individual/family served

   iv) Effective in facilitating goal attainment

c) Crisis Planning – Identifies:

   i) Indicators of an approaching crisis

   ii) Factors/activities which reduce problematic behaviors/situations and promote coping/well-being, including persons/supports to engage in managing the crisis

   iii) Factors which exacerbate problematic behaviors/situations

d) Transition Planning – Identifies:

   i) Indicators of readiness for transition

   ii) Transition outcome/goal

   iii) Actions, activities, services, or supports needed to ensure a successful transition

   iv) Progress toward the outcome

4) MONITORING, COORDINATING, and ADJUSTING SERVICE DELIVERY

This element is essential to positive outcomes. In many settings, Case Managers, in their uniquely comprehensive view of the individual and the service system, are expected to accomplish the following:

a) Function as the principle providers of coordination

b) Ensure that each involved service provider understands that services must produce the positive outcomes identified in the service plan

c) Coordinates multiple services to ensure the provision of necessary services and continuity of care while avoiding duplication of services

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d) Ensures that services are effective and satisfactory for the individual

e) Ensures that services are provided in the least restrictive setting

In order for services to be effective, two (2) conditions must be met:

a) CM services must be appropriate for the individual/family

b) The individual's/family's utilization of (CM) services must be appropriate

The actualization of these conditions is evidenced by the individual showing progress, or at least maintaining stabilization, in the community. If these conditions are not being met, adjustments must be made to help the individual engage more effectively or to more effectively engage significant others.

An effective service delivery system requires that the Case Manager is in partnership with the individual and central within the system of providers. The Case Manager's ability to professionally fulfill the duties of this role requires a comprehensive array of skills and knowledge, including, but not limited to, the following:

a) Knowledge of other involved providers and services

b) Knowledge of laws, regulations, and standards as determined by applicable governmental, regulatory, accreditation, and payer entities

c) Ability to communicate with providers - knowing the "language" of the involved professions and providers

d) Ability to conceptualize and present the individual's situation

e) Ability to facilitate meetings with individuals, networks, and providers

f) Ability to implement the interventions described in the service plan

5) CONTINUITY, TRANSITION PLANNING, AND TERMINATION

Case Management provides the linking relationship across all services and supports. This critical quality of case management applies in occasions of transition, including at the point of completion of case management services, as well as other transitions in the individual's life.

Transitions between services and service providers must:

a) Be carefully managed, as individuals are more likely to be at risk when in transition

b) Involve individuals in the development of all transition plans as described above

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c) Provide outreach to, and follow-up with, individuals to ensure that basic supports and the service linkage function are maintained during transitions

d) Apply to transition between levels of case management and discharge

e) Consider individual desires and choices when possible

f) Ensure that the individual's functioning personal resources, supports, and psycho-social stressors are as stable as possible prior to the transition to a less intensive level of Case Management

Whenever possible, there should be an overlap period where the current Case Manager or Case Management team is available to the individual during the transition period.

IX. INTEGRATIVE QUALITIES

The integrative qualities described below infuse, facilitate, and guide the service delivery process.

1) CRISIS PREVENTION, INTERVENTION, and MANAGEMENT

This fundamental function is more comprehensive than the immediate interventions implemented at a time of acute crisis (e.g., high risk of harm). It is addressed in, and accomplished through, the process of assessment, conceptualization, and service/crisis/transition planning (as described above). It is facilitated by meeting basic needs, completing plan-based interventions, appropriately and effectively utilizing services and supports, and skill-building.

2) MANAGING RISK

Safety is of paramount importance to all persons involved in the individual's life. As with Crisis Prevention, Intervention, and Management, this fundamental function of identifying, assessing, and managing risk is accomplished through other functions, including screening, assessment, and service planning and implementation.

3) EXPLORING and RESOLVING AMBIVALENCE, INCREASING MOTIVATION, and OBTAINING COMMITMENT

The Case Manager helps the individual to be ready, willing, and able to implement the service plan and actualize change:

a) Ready: the issue is considered by the individual to be a Priority

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b) Willing: the issue is Important to the individual, who wants/desires the change/outcome or considers it to be useful

c) Able: the individual has Confidence to execute the task (Self-Efficacy)

The Case Manager employs various strategies in doing so, including, but not limited to:

a) Increasing Self-Efficacy

b) Exploring Discrepancy

c) Discussing "Hypothetical Change"

d) Increasing "Change Talk" and Decreasing "Resistance Talk"

The result of these efforts is evident in the individual being motivated and committed to change.

4) SERVICE REFERRAL and LINKAGE

Referral and linkage to services is completed according to the goals and objectives identified in the service plan. Completing a linkage or referral may serve as an activity toward an outcome - a means towards an end. Case Managers evaluate appropriateness and effectiveness of referrals and resources.

5) OBTAINING BASIC and OTHER SUPPORTS

In order for an individual to engage in service planning and for services to be effective, basic needs must be identified and met in terms of securing related supports. Basic needs, e.g. safety, housing, and food, must be addressed and related supports must be established before less immediate needs, such as socialization, can effectively be addressed.

6) CHOICE, EMPOWERMENT, and INFORMED CONSENT

Individuals have ownership of and responsibility for their lives. Empowering individuals and following the directions chosen by the individual result in a higher degree of motivation and participation in services which result in positive outcomes. Supporting the individual in making decisions and in developing skills in decision-making can be empowering and is essential as a critical element in case management practice. Moreover, assisting the individual in accessing the information which is helpful in making informed decisions/choices is an essential part of this process.

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7) BEING MOBILE

Case management is most effectively provided as a mobile service:

a) provides the opportunity for access, engagement, assessment, and the completion of interventions

b) is least restrictive

As a result, case management services are provided in a variety of settings. It is important to note that these settings can be chaotic and uncomfortable, and, possibly, have safety/risk issues which must be managed by the Case Manager.

Related challenges may include individuals:

a) Being in crisis

b) Having multiple and/or unidentified concerns

c) Being early in the process of seeking/obtaining services

d) Having a significant history of failed services

e) Experiencing significant bio-psycho-social stressors

f) Experiencing ambivalence regarding….

   i) Need for/benefit of change

   ii) Need for/benefit of services

   iii) Role/purpose/function of services

   iv) “Involuntary” services

These challenges can best be addressed via sound service planning.

8) FREQUENCY and INTENSITY of SERVICES

In general, case management services are provided at the frequency and intensity (duration of contact) determined by the individual’s needs and the Case Manager’s judgment. More specific parameters are determined by the particular licensing, accreditation, payer, and provider entities involved.

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9) ADVOCACY

This fundamental function serves to empower the individual by doing the following:

a) Help the individual to understand their rights

b) Express and meet individual needs, wants and preferences

c) Actualize needs, wants and preferences to the individual's satisfaction

Advocacy facilitates the individual's self-determination, interdependence, and wellness-based outcomes. Although the specific techniques and strategies utilized by the Case Manager can vary, all approaches must be implemented in the least restrictive and least invasive manner possible with a view toward the individual being able to actively and independently advocate for themselves. In this way, this function is closely linked with the critical element of Skill Development.

10) NETWORK SUPPORT

Including, engaging, and providing support to an individual's network is essential in terms of working with the parents of children, adolescents, and with the extended family, significant others, and persons in an individual's network for all ages of individuals receiving services.

11) COLLABORATION with OTHER SERVICE PROVIDERS

In order to ensure positive outcomes via effective monitoring, coordinating, and adjusting of services, the above skills and knowledge must be applied in the context of strong and effective collaborative working relationships with other service providers. As is the case with monitoring, collaboration with other service providers requires an appreciation and understanding of the dynamics of systems, including both family and provider systems.

Other stakeholders can be both numerous and varied, including, but not being limited to providers of integrated healthcare:

a) Child protective services

b) Criminal justice system

c) Drug and alcohol service providers

d) Friends and other significant and essential persons

e) Managed Care Organizations and other payer and insurance entities

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f) Occupational, physical, and speech therapists, teachers, mentors, etc.

g) Other human services professionals/providers

h) Psychiatric treatment and other behavioral health providers

i) Primary and other health care providers

j) State, county, and other governmental and regulatory entities

12) EVALUATION

The practice of Case Management requires comprehensive and ongoing evaluation. Elements of this evaluation may include, but are not limited to:

a) Access to services

b) Effectiveness of services

c) Efficiency of services

d) Individual satisfaction with services

e) Adherence to NACM Case Management Practice Standards

f) Adherence to all relevant regulatory and accreditation guidelines

13) LEGAL CONTEXT

The provision of quality Case Management requires skill and knowledge related to a variety of legal issues, including, but not limited to, confidentiality, HIPAA/HITECH, duty to warn, mandated reporting and any applicable agency, local, state, or federal laws and regulations.

14) CONCLUSION and CLOSURE

Ideally, closure from Case Management services results from the progress achieved in terms of:

a) Community integration, independence and self-sufficiency, and well-being, in general

b) Completion of the goals and desired outcomes identified in the service planning process, in particular

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c) The service recipient’s choice as inherent in these processes

Fundamentally, conclusion of Case Management services results from the application of the fundamental functions and critical elements of Case Management practice within the service delivery process, including, but not limited to, service planning, frequency and intensity of services as based on need, and transition planning.

Documentation of the individual’s status at the close of the service is vital in terms of continuity, assessment, and planning relative to any future services. The completion of a meaningful and concise closure summary is helpful for this purpose, as well as for the documentation of the individual’s achievements and success, in general.

15) DOCUMENTATION

Accurate and timely documentation is an essential component of the service delivery process. In addition to being an essential component of professional CM practice documentation serves a variety of other purposes, including, but not limited to:

a) Evidence of service delivery, particularly as related to justification for funding and billing for services

b) Use in Case Management practice decision-making

c) Assessment of effectiveness of services, referencing key efforts, case goals, outcomes and unmet needs threatening case stability

d) Use in litigation

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