



COLLABORATE[®]: A Universal Competency-Based Paradigm for Professional Case Management, Part II: Competency Clarification

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ABSTRACT

Purpose/Objectives: The purpose of this second article of a 3-article series is to clarify the competencies for a new paradigm of case management built upon a value-driven foundation that

- improves patients' experience of health care delivery,
- provides consistency in approach that is applicable across health care populations, and
- optimizes the potential for return on investment.

Primary Practice Setting(s): Applicable to all health care sectors where case management is practiced.

Findings/Conclusions: In moving forward, the one fact that rings true is that there will be a constant change in our industry. As the health care terrain shifts and new influences continually surface, there will be consequences for case management practice. These impacts require nimble clinical professionals in possession of recognized and firmly established competencies. They must be agile to frame (and reframe) their professional practice to facilitate the best possible outcomes for their patients. Case managers can choose to be Gumby™ or Pokey™. This is exactly the time to define a competency-based case management model, highlighting one sufficiently fluid to fit into any setting of care.

Implications for Case Management Practice: The practice of case management transcends the vast array of representative professional disciplines and educational levels. A majority of current models are driven by business priorities rather than the competencies critical to successful practice and quality patient outcomes. This results in a fragmented professional case management identity. Although there is an inherent value in what each discipline brings to the table, this advanced model unifies behind case management's unique, strengths-based identity instead of continuing to align within traditional divisions (e.g., discipline, work setting, population served). This model fosters case management's expanding career advancement opportunities, including a reflective clinical ladder.

Key words: *case management paradigm, competency, critical thinking, leadership, nursing, professional case management, social worker, transdisciplinary*

When we last met in Part I of COLLABORATE[®], the gauntlet was tossed to propel case management from advanced practice to full-fledged profession. Independent of health care's future and never-ending challenges, case managers must be agile to frame (and reframe) their professional practice to facilitate the best possible outcomes for their patients. Case managers can choose to be Gumby™ or Pokey™. This is exactly why the definition of a competency-based case management model's time has come, one sufficiently fluid to fit into any setting of care (Treiger & Fink-Samnack, 2013, Part I).

Since COLLABORATE[®] Part I was published, we have received rich and diverse feedback about

the model, feedback we know that will continue with the release of Part II: Competency Clarification. We anticipated and encourage engagement from all perspectives in constructive discussion. Ultimately, this elevates the quality of our practice and contributes to optimal case management

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outcomes: a process that is a core element of what constitutes a profession. This is our intent and an expectation of the professional workforce to which we have each devoted our careers; one which ultimately provides high quality interventions to all of health care.

Two other points warrant comment. First, although the concept of *professional case management* underlies the overarching theme of this series, the simplified term case management is used interchangeably herein to enhance readability. Although the initials PCM could have been used, the decision not to do so was made to avoid confusion with the title of this publication. Finally, we recognize that the individual competencies that make up the COLLABORATE[®] model (see Table 1) could easily be expanded into independent articles or even into books (some of which already have that distinction). For the purpose of this article, the topics are covered as they apply to the model's scope.

FRAMING THE PARADIGM

While seeking balance and consistency, case managers must embrace flexibility by yielding to the prevailing trade winds with professionalism. Case managers face the complexity of day-to-day health care and methodically assess, plan, facilitate, coordinate, evaluate, and advocate for the client whose needs are best addressed comprehensively through clear communication and by utilizing available resources in the promotion of quality cost-effective outcomes (Case Management Society of America [CMSA], 2010, p. 8).

How does one illustrate this construct visually? The process for developing a graphic depiction of COLLABORATE[®] proved as challenging as case management itself. It was essential that the paradigm simultaneously align those tenets defined by one's standards of recognized practice and of case management. The fluid influences of industry, organization, and institutional trends layer on additional considerations. Portraying best practice at a specific point in time results in a rather chaotic image. Stepping back to examine the big picture (which case managers do so well) enables the deconstruction from a complex concept to something elegantly simple, captured by a Venn diagram (see Figure 1). Through its overlapping circles, the classic Venn diagram reveals logical relationships that exist across a multitude of considerations. Case management practice is grounded in professional competencies, and this depiction allows for the flexibility of one's individual circumstance (e.g., licensure, practice setting) and simultaneously promotes one's ultimate flexibility.

TABLE 1
The COLLABORATE[®] Competencies

Acronym	Competency	Key Elements
C	Critical thinking	Out-of-the-box creativity Analytical Methodical approach
O	Outcome-driven	Patient outcomes Strategic goal-setting Evidence-based practice
L	Lifelong learning	Valuing <ul style="list-style-type: none"> • Academia and advanced degrees • Professional development • Evolution of knowledge requirements for new and emerging trends (e.g., technology, innovation, reimbursement) • Practice at top of licensure and/or certification • Acknowledgment that no one case manager can and does know all
L	Leadership	Professional identity Self-awareness Professional communication Team coordinator
A	Advocacy	Patient Family Professional
B	Big picture orientation	Bio-Psycho-Social-Spiritual assessment Macro (policy) impact on micro (individual) intervention
O	Organized	Efficient Effective
R	Resource awareness	Utilization management Condition/population-specific Management of expectations per setting
A	Anticipatory	Forward thinking Proactive versus reactive practice Self-directed
T	Transdisciplinary	Transcending <ul style="list-style-type: none"> • Professional disciplines • Across teams • Across the continuum
E	Ethical-legal	Licensure Certification Administrative standards Organizational policies and procedures Ethical codes of conduct

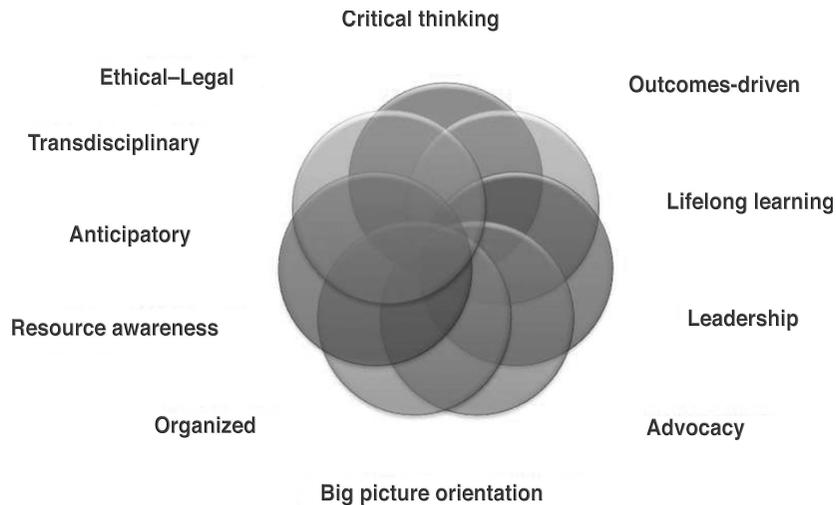


FIGURE 1
The COLLABORATE® paradigm.

THE COLLABORATE® MODEL: COMPETENCY CLARIFICATION

CRITICAL THINKING

Key elements:

- Out-of-the-box creativity
- Analytical mindset
- Methodical approach

Expediency is the enemy of integrity.

—Ellen Fink-Samnick

Critical thinking (CT) has seen a resurgence over the past decade, especially in the health and human services realm. The positioning of CT as initial competency of COLLABORATE® is deliberate. This hallmark for professional decision-making is not only a competency in its own right but also integral to each of the ones that follow: from analysis of ethical dilemmas to in-the-moment assessment of patient safety or one's ability to define outcome measurements.

Critical thinking provides the rich opportunity to individualize and objectively analyze various situations. Facione and Gittens (2013) define *CT* as “purposeful, reflective judgment that manifests itself in giving reasoned and fair-minded consideration to evidence, conceptualizations, methods, contexts, and standards in order to decide what to believe or what to do” (p. 4). Gambrill's (2012) perspective equally views CT as purposeful, with enhanced emphasis on standards of clarity and fairness, along with careful consideration of beliefs and actions to arrive at well-reasoned decisions (p. 11).

Many models have been posed in the literature to engage CT. Ward's (2012) 3E model is especially applicable for case managers:

1. Examine the issue through identification of the issue at hand by the use of strategic open-ended questions and collecting evidence related to it.
2. Explore the information through creative interpretation. Suspend judgment, recognize assumptions, and interpret information objectively. Brainstorm alternatives and solutions recommended as well.
3. Evaluate the information by assessing explanations and solutions, and then working to reach a conclusion. (p. 35)

This unique model is based on aligning the pivotal analysis and decision-making elements of professional practice with fundamental action-oriented phases. Possessing the confidence in having done due diligence with the entire problem-solving effort is often far more important than agreeing or disagreeing with one's original hypothesis. Let this model (shown in Figure 2) ground your own CT efforts.

The key elements of the CT competency include the following.

Out-of-the-Box Creativity

Simpson and Courtney (2002), in their article *CT in Nursing Education*, explore the fundamental grounding of the dimensions of CT and distinctions as opposed to more traditional problem-solving, clinical decision-making. They set the foundation for CT as a process that fuels a more ingenious effort, a blending

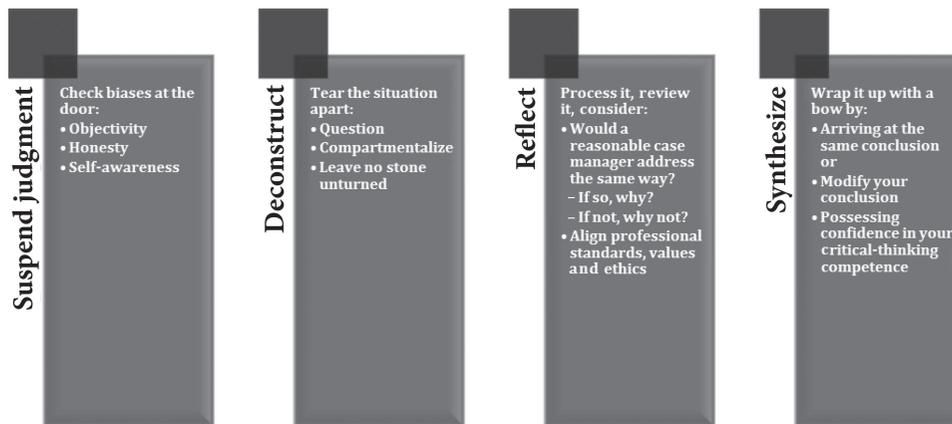


FIGURE 2 Critical thinking for professional case managers. Adapted from “Critical Thinking in Child Welfare Supervision,” by C. Lietz, 2010, *Administration in Social Work*, 34(1), pp. 68-72.

of knowledge and creativity. “Creative thinkers employ an attitude of interest in everything, continuously exploring for new ideas, options, alternatives, and approaches” (Simpson & Courtney, 2002, p. 94).

Herein lies the alignment with *professional case management* practice, “In order to step outside the everyday reasoning and approaches to problem-solving, a person needs to develop an imagination of the possibilities and potentials inherent in a particular circumstance. This often demands a creative leap of faith and a willingness to be ‘playful’ with future possibilities” (Simpson & Courtney, 2002, p. 94).

Analytical Mindset

Although CT is integral to evidence-based practice, it allows one to accurately describe to what extent the related underlying research can rigorously test established practice (Gambrill, 2012, p. 12). One might emphasize that CT strives to go beyond the black and white of prevailing research to address the gray:

- clear versus unclear
- precise versus imprecise
- specific versus vague
- accurate versus inaccurate
- relevant versus irrelevant
- consistent versus inconsistent
- logical versus illogical

- deep versus shallow
- complete versus incomplete
- significant versus trivial
- adequate for purpose versus inadequate (Gambrill, 2012, p. 11).

Each of the above realities manifests for case managers across their diverse roles, settings, and associated functions.

Methodical Approach

The goal of CT, by its very premise, is to approach decision making from a strategic perspective toward the purpose of well-reasoned decisions (Gambrill, 2012, p. 275). Although there is great variation and perspective in how this approach is implemented, there is consensus on both the merit of templates to this end across health care professional disciplines and on CT’s vital role for the industry. Whether a case manager utilizes one of the CT models posed or another unique rendering, utilization of a formal framework is vital to ensure a proactive, logical, and purposeful action.

This case manager for a Medicare Advantage population addresses the following situation from the COLLABORATE® perspective. She is faced with the challenge of engaging patients in meaningful dialogues to define and ensure that their advanced directives are in place. This issue remains unresolved despite powerful community media attention and strong efforts by primary care physicians. This is also a topic the case manager has mixed feelings about. She appreciates the importance of self-determination and the underlying professional values to support a patient’s decision making. However, she also knows the huge impact it may have for family members.

The medical director has asked the case manager to develop a proactive plan to address this situation;

While critical thinking is integral to evidence-based practice, it allows one to accurately describe the extent to which the related underlying research can rigorously test established practice.

one which expands this program to all populations across the clinical resource management department. Considering the enormity of this project, the case manager uses a CT template to move this process forward.

First, the case manager suspends judgment, dialoguing with her mentor about all personal and professional biases. As tough as this level of honesty may be, it is essential to ensure viewing both the situation and assignment objectively. A high level of self-awareness is an asset with this step. Keeping the plan in mind, the case manager wonders how her bias about the topic itself impacts her intended approach. The importance of the project translates to knowing that a personal perspective is not a welcome visitor to this process.

Next, the case manager identifies what challenges have impacted the implementation of this effort in the past. Previously completed outcomes are available and reviewed extensively. A questionnaire is then developed to survey the physicians on the basis of the obstacles noted in the outcomes, as well as to obtain their interpretations of the data. Other case managers for the Medicare Advantage population are also surveyed. A comprehensive and strategic presentation is defined to address vital areas of the project focus, historical challenges, new survey results, and the implementation plan.

The third step involves the case manager reviewing the presentation and planning with a mentor. Established case management standards are recommended to insert as references to ensure professional grounding. The mentor has additional suggestions and inquires about the rationale behind this approach. Together, they revise the plan.

Arriving at the fourth stage, the case manager is now confident that due diligence in devising a workable solution to the situation has been achieved. The time lines for implementation are a major adjustment from the original version, though she now suspects the preliminary version was related to subjective bias on her part. With this issue, plus others fully addressed, the case manager is ready to engage purposefully and confidently with this effort.

OUTCOME-DRIVEN

Key elements:

- Client
- Strategic goal-setting
- Evidence-based practice

You may never know what results come of your action, but if you do nothing there will be no result.

—Mahatma Gandhi

The Agency for Healthcare Research and Quality (n.d.) defines an *outcome* as the end result of health care practices. Outcomes measure effectiveness of an

Within case management, an outcome is the measurable result of a case management intervention, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle or the result or consequence of the care received, as well as care that was not received.

intervention and may also indicate whether a change of course is advisable. Within case management, an outcome is the measurable result of a case management intervention, such as client knowledge, adherence, self-care, satisfaction, and attainment of a meaningful lifestyle (CMSA, 2010, p. 26), or the result or consequence of the care received, as well as the care that was not received (Powell & Tahan, 2010, p. 230).

Key elements of the outcomes-driven competency are as follows.

Client

The COLLABORATE® perspective focuses on client outcomes. The outcomes-driven case manager focuses on maximizing his or her client's health, wellness, as well as other considerations. This approach is at the heart of the case management philosophy; the underlying premise is that when an individual reaches an optimum level of wellness and functional capability, everyone benefits (CMSA, 2010, p. 9). Outcomes is also a practice standard demonstrating the value of case management intervention in terms of plan-of-care goal attainment, the use of evidence-based criteria and guidelines, and measures of client satisfaction (CMSA, 2010, p. 17).

Strategic Goal-Setting

When working with the client and the care team to establish goals, it is essential to consider the appropriateness of the goal itself. Goals that are unattainable are frustrating and frequently defeat the case management intervention itself. Goal setting needs to be strategic in taking client variables such as readiness and willingness to participate, whether the desired outcome is achievable, and whether the case management engagement is anticipated to be long enough to reach the desired outcome. The use of interim goals (considered baby steps to the desired long-term result) is quite helpful with regard to situations where the factor of time may be limited. Using short, intermediate, and long-term goals facilitates client engagement in the case management plan and helps alleviate discouragement when a client

begins to feel as though he or she is not making enough progress within a given time frame.

To the point of strategic goal-setting, the use of the S.M.A.R.T. (an acronym for Specific, Measurable, Attainable, Relevant, and Time-bound [Doran, 1981]) methodology assists the outcomes-driven case manager to optimize the prospect of success. The concept of S.M.A.R.T. goal-setting is especially applicable to the healthcare setting because this framework can be leveraged to assist each client in the identification of realistic goals. The case manager is critically important to the collaborative process of managing expectations through the development of goals that are reasonable and achievable within the context of understanding the client's health condition(s), his or her capacity and ability to perform tasks and responsibilities, and his or her knowledge of the resources available to each client. When carefully considered, wisely worded, logically organized, methodically approached, and appropriately time-framed goals are tremendously valuable to enhancing client motivation. With each accomplishment comes a growth in a client's self-confidence as well as a desire to take the next step. With each setback comes the challenge in learning valuable lessons because the professional case manager is able to turn an unsuccessful situation into a win by using coaching and motivational skills (Treiger, 2012, p. 22).

Evidence-Based Practice

The Institute of Medicine (2001) defines "evidence-based practice" as a combination of the following three factors: best research evidence, best clinical experience, and consistency with patient values. Where case management practice is concerned, evidence-based practice is important for reasons including, but not limited to, quality, access to care, safety, and cost, examples of case management-influenced outcomes are presented in Table 2. There are many kinds of evidence, and rating conventions vary according to the review source. Although evidence-based practice is an essential skill for case managers to possess, few have the time or resources to complete the extensive literature reviews and analyses required

to found every function of their work on solid evidence (Throckmorton & Windle, 2009, p. 226).

More commonly, case managers rely upon evidence-based tools such as health condition guidelines and decision-support criteria on which to base authorization decisions, develop case management plan interventions, and anticipate future client needs. These serve as that valued resource allowing the case manager to be proactive in planning, educating the patient and the multidisciplinary team, as well as anticipate transition needs and scheduling. Utilizing these tools assists the case manager in facilitating quality-focused and timely medical services for the consumer (Powell & Commander, 2007, p. 1).

COLLABORATE[®] takes the perspective that the outcomes-driven case manager should understand the essentials as to evidence-based practice and the value associated with basing care interventions on reliable, objectively proven information. The case manager utilizes evidence-based findings as rationale for his or her activities, such as care planning, authorization requests, and health education efforts. Evidence-based practice contributes toward effectiveness and efficiency of the associated interventions.

LIFELONG LEARNING

Key elements:

Valuing

- Academia and advanced degrees
- Professional development
- Evolution of knowledge requirements for new and emerging trends (e.g., technology, innovation, reimbursement)
- Practice at the top of licensure and/or certification
- Acknowledgment that no one case manager can and does know all

The more I live, the more I learn. The more I learn, the more I realize, the less I know.

—Michel Legrand

Education and learning are cardinal values instilled during the formative years of many and are

Table 2
Case Management-Influenced Outcomes

Quality	Access to Care	Safety	Cost
"Case managers have the capacity to balance quality and cost in many health care settings, and particularly in the case management of patients with chronic health problems near the end of life" (Stanton & Packa, 2010, p. 27).	"...there is ample evidence of the need for professional case managers to undertake a care coordination role to improve delivery of health services to patients" (Consomery-Fairnot & Serbin, 2012).	"The aims of effectiveness and safety are targeted through process-of-care measures, assessing whether providers of health care perform processes that have been demonstrated to achieve the desired aims and avoid those processes that are predisposed toward harm" (Hughes, 2008, pp. 3-1).	"Outcomes at the organizational level include: aggregate clinical; functional; and quality outcomes; as well as costs of care; lengths of stay; re-hospitalizations; use of acute services; cost benefit; return on investment; and satisfaction rates for different patient populations" (Stanton & Packa, 2010, p. 26).

as unique as each human being. These experiences, and how each case manager reflects on them, shape how one engages in continued educational endeavors. Enjoy the reflection, shown in Table 3.

Few would argue of the amount there is to continuously learn in the healthcare industry. Knowledge is truly power, so it is not surprising how many take pride on being avid learners. This may be driven by adherence to any one of many professional standards and codes of professional conduct in the industry. Case Management Society of America (2010) Standards of Practice for Research and Research Utilization presents a case manager's responsibility to maintain familiarity with current research findings and be able to apply them, as appropriate, in his or her practice. Perhaps it might relate to the Commission for Case Manager Certification's (2009) Code of Professional Conduct, which speaks to certificants maintaining their competency at a level that ensures each of their clients will receive the benefit of services appropriate and consistent for their conditions and circumstances. The National Association of Social Workers (NASW) Code of Ethics and the administrative regulations which underlie social work clinical licensure are clear in their direction to the workforce. Both mandate that each professional should advance their knowledge base, develop and enhance professional expertise, and continually strive to increase professional knowledge and skills to apply them in practice (NASW, 2008). Some professionals possess an innate drive to educate and empower the knowledge of others, from students to new or even more seasoned professionals. Whatever the etiology, the goal should be to continue to learn every day from each interaction and experience that one has, whether it is with a patient or another professional. Each of these experiences provides additional data for that "lessons learned" file we should each possess.

Addressing new trends comes with this territory. Technology proficiency is a factor many have embraced, although others have resisted. Most case managers use some element of technology daily, whether for entering or reviewing documentation in an electronic health record or simply contacting a colleague via a mobile device. Many continue to feverishly grasp the full scope of Health Insurance Portability and Accountability Act of 1996 (HIPAA)—Health Information Technology for Economic and Clinical Health (HITECH) 1, 2, and now Final Rule with HITECH 3 released in January 2013. Recent studies validate that innovation is here to stay. The value of the global medicine market grew from \$11.6 billion in 2011 and is expected to hit \$27.3 billion by 2016. At the time of this writing, 2.8 million patients were being remotely monitored (Lewis, 2012); 60% of the 8,745 persons surveyed move between anywhere from one to three mobile devices each day to access health information (Manhattan Research, 2012). It is not uncommon for case managers to discuss the technology evolution as a precipitator for early retirement.

The key elements of the lifelong learning competency include the valuing of the following.

Valuing

- Academia and advanced degrees
- Professional development
- Evolution of knowledge requirements for new and emerging trends, and
- Practice at the top of one's licensure and/or certification

Our environments are full of learning opportunities. From the COLLABORATE[®] perspective, this plays out as follows:

- You start your case management career at a large managed care provider. You take to it instantly, appreciating the big-picture orientation, the

TABLE 3
Lifelong Learning Reflection

It is Always Something

Although both of my parents emphasized the importance of knowledge expansion, it was my older brother's wisdom that held critical messaging, at least for me. When I received my Master of Social Work, I remember feeling elated that my formal education was now complete with the confirming of my degree, or so I thought. I can recall standing with my peers following the convocation ceremony when my brother approached me and said, "Sis, I hate to burst your bubble, but your learning is far from complete. If you are lucky you will learn for a lifetime." I remember feeling a tad disappointed. However, upon accepting my first professional role and entering the healthcare industry, I quickly realized that truer words were never said.

My new role as the social worker at a busy community hospital in 1983 found me playing sponge to anything to support my mastery of the role. There were organizational policy and procedure manuals, ever-changing state and federal regulations, plus a bottomless pit of population-specific resource information that was added to with each new illness and societal trend. There were funding, entitlement, and insurance issues to also familiarize myself with. Then came licensure and specialty certification standards with new ones mandated by each promotion and/or position change, each with distinct continuing education requirements. Of course, then the bug bit me to return to school for those post-masters' degrees. I would also add that these events all occurred before I obtained my case management certification in 1993, and we all know what that learning curve is like! It is overwhelming now, to reflect back and consider how much of this also occurred prior to the latest generation of innovation and technology.

—Ellen Fink-Samnack

transdisciplinary interaction, and attention to outcomes. After several years on the job, you sit for your clinical social work licensure plus case management certification, viewing both as essential to denote competence and future opportunities.

- You are promoted to a team leader, responsible for a new population-based integrated behavioral health program. Hungry for advancing your practice to the highest level, you review evidence-based treatment protocols for patients with anxiety disorders and chronic obstructive pulmonary disease. Several journals have current literature on the topic, and you schedule time to read a minimum of one article monthly.
- You focus on registering for related online continuing education programs to ensure a comprehensive knowledge base, though feel equally ready to ramp up your practice to another level. You have lunch with your mentor, who encourages you to coauthor an abstract for an upcoming conference presentation. “You constantly discuss how to optimize transdisciplinary team documentation for the new electronic health record system. You should submit that for the upcoming conference presentation,” she says. When the abstract is accepted, you are suddenly inspired, although a bit nervous. You decide to step up and seek to obtain your PhD in case management under a new program cosponsored by the social work and nursing departments at a nearby university. That presentation abstract serves as the foundation for your dissertation.

Acknowledgment That No One Case Manager Can and Does Know All

From the COLLABORATE[®] perspective, it can be dangerous to think any one professional possesses all the knowledge in the universe. This case manager for a Level 1 trauma hospital emergency department learns this lesson quickly. She has seen it all over the past 10 years, so she thinks. Of course, with the current flu epidemic decimating her department, three case managers have called in sick, and she has been pulled to cover the ambulatory surgery unit.

Three hours later she is swamped. It is not because of the number of patients or their reviews but related to intense family dynamics for several pending discharges. The tension between one patient and his daughter is spilling over to the already chaotic unit. The case manager may be an expert in team dynamics from her years in the ED, however family dynamics are another story. It could be easy to leave the situation be, but knows it will be better for the patient, the daughter, plus team members if it can

somehow be de-escalated. The case manager suddenly remembers that a colleague in the intensive care unit has expertise in working with families, and she calls her. The colleague was about to call in a clinical review but has a thought that perhaps the mutual tasks can be switched and she is glad to address the family situation. “Besides you can’t be all things to all people, I got this,” says the colleague. Nothing like team camaraderie!

LEADERSHIP

Key elements:

- Professional identity
- Self-awareness
- Professional communication (verbal/nonverbal)
- Team coordinator (a unifier rather than a divider)

If your actions inspire others to dream more, learn more, do more, and become more, you are a leader.

—John Quincy Adams

Healthcare is dynamic. Everything about the industry is in a state of continuous change. This dynamism flies in the face of the natural function of maintaining homeostasis. As individuals, humans approach change with varying reactions from outright denial to a full and hearty embrace. A leader, as described by Kotter (2011), recognizes the urgency of a situation and wants to make things happen. Being a leader requires vision and the ability to inspire people to reach beyond what they believed was possible. A leader empowers individuals around them to accomplish goals and surpass expectations. A leader has a sense of purpose primarily focused on advancement of the industry, rather than of personal gain.

When addressing the leadership competency, it is essential to remember that case management leadership happens in every aspect of practice and professional identity—from academia and professional associations where formal education and training provide the theoretical and practice foundation to supervision and management where policy and procedure reflect practice standards and evidence-based research to the frontline where effective and efficient hands-on coordination of care is based on skill

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strengths and abilities guided by client goals in partnership with a professional case manager and health care team.

Leadership is born from a desire to establish and advance our professional practice. It has little to do with organizational hierarchy or a self-aggrandizing personal agenda, but rather it has everything to do with leveraging assets (and shoring up liabilities) toward best practice and optimal outcomes. The case management industry (yes, we should be considering ourselves an industry!) must come to a consensus that leadership development is a critical challenge that requires additional study and attention. Although the trickle of incoming case managers is acknowledged as problematic, efforts focused on recruitment are not making an appreciable impact. So what might that mean? Could it be a lack of followership? In an April editorial, Bersin (2013) recognized that the three key points of followership are as follows:

1. We follow people with character because they have a moral compass.
2. We follow people who help us grow because they respect and bring out the best in each of us, help us do great things, and help us understand how to overcome our own weaknesses.
3. We follow people who have their own unique strengths and weaknesses, which make them real.

When put under that light, instead of entreating newcomers with sign-on bonuses and more consistent work hours, we should be developing leaders to be people who are worthy of being followed?

Key elements of the leadership competency highlight the following.

Professional Identity

An essential perspective shift is required to embrace the COLLABORATE[®] approach. Regardless of practice setting or administrative hierarchy, a case manager regards himself or herself as a leader and demonstrates this attribute through being an integral member of the health care team and an advocate for the client. COLLABORATE[®] fixes a spotlight on the *professional case manager* who leverages the tools and resources at his or her disposal to provide thoughtful

case management interventions that add value, rather than layers, to the delivery of health care services (T. M. Treiger, personal communication, 2008). The *professional case manager* applies his or her knowledge and experience in the form of clinical judgment, ensuring optimal, cost-effective quality care, and leads by facilitating the care delivery process.

It is by weaving professional identity through every COLLABORATE[®] competency and key element that we create a fabric of sufficient strength to bind seemingly disparate (and occasionally competing) agendas into a cohesive synergy focused on crafting a consensus statement that clearly articulates the value of all case management stakeholders as well as identifies their individual contributions to the advancement of *professional case management* from a concept to a reality.

Self-Awareness

Self-awareness is considered the ability to engage in reflective awareness and is associated with executive processes essential to self-regulation. The self-aware individual is considered as controlled and intentional in his or her actions (Hull, 2007, p. 791). In the context of case management, a leader is mindful that every interaction leaves a lasting impression both of him or her as an individual and of what case management is (or is not). It is essential to understand that how one conducts himself or herself is as important as the end result. Always keep in mind one's own experience with resolving a customer dispute or getting a question answered satisfactorily. Enduring a frustrating call center transfer process frequently overshadows the fact that one obtained the desired outcome.

Leadership is also inclusive of the self-regulation concept. By definition, *self-regulation* means that society confers a group with the mandate to police itself. Because case management requires specialized knowledge to effectively practice case management, it follows that case managers are in the best position to accomplish this oversight responsibility. However, this privilege is accompanied by immense accountability. As leaders, we must address the wide variation in factors, such as scope of practice, licensure,

By definition, self-regulation means that society confers a group with the mandate to police itself. Because case management requires specialized knowledge to effectively practice case management, it follows that case managers are in the best position to accomplish this oversight responsibility. However, this privilege is accompanied by immense accountability.

education, and title recognition, in an organized and methodical manner to ensure that every case manager is held to the standards of practice and ethical constructs of his or her respective license *and* also to what governs case management practice. As leaders, we continuously monitor ourselves (and our colleagues) to ensure practice within these limits. When we lack knowledge required for safe practice, we seek additional information to build and advance our competence level.

COLLABORATE[®] highlights a case manager who considers himself or herself an important member of the care team and seeks opportunities to let each client know who and what he or she has to do as part of the care team. The manner in which an initial introduction is conducted is essential to establishing the relationship basics. For instance, when entering a client's hospital room, the case manager introduces himself, "Good morning, Mr. Cote. My name is Edward. I am a case manager here at General Hospital. I am going to help to coordinate the services you need during your hospital stay and make sure your transitions needs are taken care of when it is time to leave the hospital. Things like follow-up appointments, prescriptions, and home services," (see Table 4).

Profession Communication

A leader shows respect for cross-continuum care team partners by working toward a goal, using mindful and evocative communication techniques. This approach is a hallmark of the case management philosophy. The case manager leader considers the tone, appearance, and impact of verbal, nonverbal, and written communication and uses a clear and concise approach in the course of conducting business.

The COLLABORATE[®] perspective features a case manager who approaches a colleague sitting

The case manager leader considers the tone, appearance, and impact of verbal, nonverbal, and written communication and uses a clear and concise approach in the course of conducting business.... A leader does not make assumptions about what solution may work best but, instead, seeks to gain consensus across the care team.

at a work station and begins the communication by saying, "Do you have a moment to talk about the transition plan for Mr. G?" This contrasts to firsthand witness accounts of case manager dropping a pile of paperwork and declaring, "What are you going to do about getting Mr. G out of here?" COLLABORATE[®] emphasizes that a considerate and professional approach be taken in all interactions. In this case, simply inquiring about timing allowed for a meaningful conversation would signal that one values the individual's time and attention, rather than assume it was convenient to interrupt and launch into a detailed discussion of a patient's needs and goals without recognizing that the person was in the process of performing important tasks. The same is true of telephone interactions and Internet-based chat. The *professional case manager* who conducts non-face-to-face interactions is mindful that even prearranged appointments may end up being inconvenient for the recipient. Although this may be an oversimplification of the element, this is another transcending competency that begins at a very basic level.

TABLE 4
You Only Have One Chance to Make a First Impression

The Situation	What Went Wrong?
<p>A story that highlights the way one does not want to introduce himself or herself to a patient was an encounter of a colleague of mine. Unfortunately, this is not the first time I have heard of a similar scenario. In this case, a colleague's mother was hospitalized in an acute hospital facility. My colleague was at the bedside chatting when into the room bounds a woman with a clipboard, attired in a lab coat over her street clothes. A name tag clipped to the collar was flipped around backward, so it was impossible to know who she was or what she was there to do. She announces, "Hi, my name is Mary. I'm a case manager. It's my job to get you out of the hospital and get the hospital paid." Oh, where do I begin to capture all of the things that are wrong with this interaction? In response to this, the patient turned to her daughter with a rather bewildered look and asked, "And this is what you do?"</p>	<ul style="list-style-type: none"> • Failure to knock on the room door • Failure to ensure the name tag was positioned to be easily read • Failure to ask if it was a convenient time to talk • Failure to complete a formal introduction • Failure to acknowledge the patient by name • Failure to acknowledge the patient had a visitor <p><i>And perhaps the most egregious failure...</i></p> <ul style="list-style-type: none"> • Reducing the scope of case management's responsibility to getting a patient out of the hospital and getting the hospital paid.
<p>—Teresa M. Treiger</p>	

Written communication also deserves more focus. Certainly, there are existing challenges with traditional communication, which must be addressed. However, a risk of advancing technology that deserves mention herein is that of overcasualization of professional interactions. In this context, overcasualization refers to the fact that we use texting and other word-based messaging (e.g., texts, instant messaging, Facebook) to conduct personal interactions and these forms are infiltrating professional channels as well. Although ensuring HIPAA–HITECH compliance in healthcare communication is essential, making sure that all written messages are clear, complete, and professional is a responsibility of every organization and individual. The professional case manager leads through example-setting as to the essential propriety of all communication (e.g., spelling, grammar, tone).

Team Coordinator

A leader does not make assumptions about what solution may work best but, instead, seeks to gain consensus across the care team. As a high-functioning member in every team of which he or she is a part, the case manager strives to work effectively with other team members. As a coordinator of care, the case manager facilitates the completion of tasks, consistently encouraging other care team members, especially the client/caregiver, to take action rather than personally performing every intervention.

COLLABORATE[®] frames this with the case manager seeking out opportunities to discuss issues and the care plan with the client: setting priorities on the basis of client need. The leader case manager considers confidentiality as an inherent part of the coordination process, ensuring that the client is aware that information is being shared with fellow care team members to facilitate his or her care.

ADVOCACY

Key elements:

- Patient
- Family/support system
- Professional
 - The individual
 - The profession

Be the change that you wish to see in the world.

—Mahatma Gandhi

Advocacy is a force which propels a case manager's efforts, whether infused through education, licensure regulations, certification, or professional standards. It is no wonder that we include it as an integral component of COLLABORATE[®].

Social workers are weaned on advocacy by virtue of professional heritage. The original mission of social work involved championing the rights of society's most vulnerable members, from children to the homeless and those with physical disabilities (NASW, 2013b). Equal importance to advocacy is placed by the nursing profession, particularly through dedication to patient safety and nursing quality, as well as by creating initiatives that raise awareness among legislators and the general public toward safe patient handling and patients' rights (American Nurses Association, 2013).

Interpretations vary on how advocacy is implemented within each case manager's realm. As a process, advocacy promotes beneficence, justice, and autonomy for clients that aim to foster the client's independence (Commission for Case Manager Certification, 2009). As an action-oriented case management function, one engages his or her energies for clients at the service-delivery, benefits-administration, and policy-making levels, demonstrated through defined behaviors. These include ensuring client self-determination, shared decision-making, education of other involved health care providers, plus recognition and elimination of disparities in accessing high-quality care. Others participate at the macro level in working to expand or establish services and for client-centered changes in organizational and governmental policy (CMSA, 2010).

Amid health care's vast transitions of care and what can be viewed as a rocky road with unpredictable detours and obstacles, patient advocacy has been propelled into the forefront of interventions. This heightened attention to protecting the public has yielded distinct certifications and professional associations focusing on improving the way people interact with and experience the healthcare system by supporting public education to foster effective self-advocacy (National Association of Healthcare Advocacy Consultants, 2013). The National Association of Healthcare Advocacy Consultants and the Professional Patient Advocate Institute (2013) support the inclusion of all interested professionals across the myriad of involved disciplines of origin. Although there is merit to support for the importance of consumer advocacy in the health care realm, many challenge that this focus is endemic to case management's professional core. This further cements advocacy's position as a defined competency in this model.

The key elements of the advocacy competency include distinctions between the following.

Patient and Family/Support System

A majority of case managers have an easier time advocating for their patients and families than they do for

themselves. It is an occupational hazard for health and human service professionals to prioritize the needs of others in lieu of their own (Fink-Samnack, 2007).

Most professional case managers know how to advocate for those who they intervene on behalf of and aspire to do so. However, a lengthy list of impeding priorities impacts their ability to fulfill this goal. Amid the powerful daily influences of time management plus what presents as the paramount responsibilities of clinical reviews, data entry, and outcomes completion, the extra time and energy needed to advocate for others evades us. One might also contend that a case manager's adherence to advocacy as a competency can be enhanced through commitment to achieve balance between occupational stressors and life challenges, while fostering professional values and career sustainability (Fink-Samnack, 2009).

In this COLLABORATE[®] moment, the case manager for an acute rehabilitation hospital is working with a patient who has suffered a traumatic brain injury. The family is supportive, though having a difficult time adjusting to the patient's unknown prognosis. Their frustration is directed at the team, the case manager, the system, and anyone else they can think of.

The team has defined that the patient would benefit from an additional week before transitioning home. The family reluctantly agreed and is receiving training to enhance their confidence with the patient's scope of care. The worker's compensation case manager left you a voicemail saying, "The patient can accomplish the goals defined at a lower-level of care, which is more cost effective. It is the strong recommendation of our medical director that the patient be transferred tomorrow to a local subacute nursing home for the next 2 weeks. They can address the remaining issues needed to discharge the patient directly home."

It might present that this is the answer to your prayers, especially amid your three new admissions that day and four other discharges for that week. Although this plan is wrapped up with a bow, you know it is far from this patient's best interests that she be forced to orient to a new treatment environment with new team members. The family is horrified and concerned about the transfer. You define a plan with the transdisciplinary team to:

1. Review the fiscal disincentives of the transfer, including potential treatment time lost for the patient amid the transfer in the context of their diagnosis implications, accompanied by the daily cost to the payer to denote return on investment.
2. Define goals and objectives for each discipline involved, with team coordination to address specific issues such as compensatory strategies to maximize external distractions impacting functional ambulation to manage steps, curbs, home safety,

and other issues, which would promote further self-sufficiency for the patient.

3. Consider the use of other health care benefits to cover the continued stay or negotiate a more favorable per diem rate with the payer.
4. Direct communication between patient's attending physician and payer medical director.
5. Involve the family in the process so they feel empowered. They get to advocate for the patient, and you get to advocate for all of them. You explain the strategy that if the plan to extend the patient's stay is not approved, the family is to spring into action and contact the patient's employer. As a group-administered policy, which covers some 250,000 lives in the region, the group administrator has offered to contact the insurance company to mandate they extend the benefit to cover the continued days.

Professional

This element cuts to the core of a case manager's professional identity. It involves how to put that professional foot forward, occurring at levels to address the needs of the patient as well as the case management profession itself.

The Individual

Individual leadership (self-leadership) begins with the case manager recognizing the importance of how to present him or herself as a health care professional. This involves implementation of solid and eloquent communication, whether written, verbal, or even nonverbal messaging. This extends to those skills and strategies used to effectively manage and lead a transdisciplinary team. Case managers are team leaders and expected to facilitate the care coordination process. This involves the skillful art of negotiation to obtain authorization for extended days, treatments, or other identified resources for patients. How a case manager connotes unique expertise is critical to the success of his or her individual professional effort.

Consider this scenario to frame the COLLABORATE[®] approach. A case manager enters a team meeting, which is anticipated to be challenging. There have been messages left by assorted team members plus the medical director about a payer decision not to approve an admission to an acute rehabilitation facility. The case manager is equally dissatisfied and, at first impulse, wants to align with team members and engage in the toxic talk about the payer, the insurance industry, and health care reform. However, this case manager exercises self-control and "takes the high road" to set an example. As the team leader, her role is to ensure objective and strategic action amid reality. To begin, she says, "Ok all,

I know this is a tough one, but let's use our precious energy purposefully. I want us to dedicate our concerted effort and develop one rocking plan to appeal this decision, so let's begin."

The Profession

There are many ways in which case managers advocate for our profession. This article's focus is one means to accomplish advocacy at this level, as our established theme involves motivating case management from advanced practice to profession. Some opt to engage in a professional association public policy committee and/or contributing to the efforts toward title protection, licensure portability, defined competencies, and other initiatives, which promote the concept of *professional case management*.

From the lens of COLLABORATE[®], the case manager feels strongly about being devalued by his employer. Other case managers in both the organization and professional community have experienced this but let it go as "just the way it is." Noticing the amount of discrepancy in the literature, the case manager complains bitterly to colleagues at a CMSA meeting. "We have to do something about this," he says. "We all keep saying we don't have time to address this; however, we can no longer avoid it. Look at the time and energy we invest in this topic at every turn. Some proactivity on the front end will minimize the time we will spend in the future."

BIG-PICTURE-ORIENTATION

Key elements:

- Bio-Psycho-Social-Spiritual assessment
- Macro interventions on micro practice

Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.

—Albert Einstein

Case management is about the big picture, but how big is your screen? Do you watch on a smart television with high definition to see each intricate detail or on perhaps a more traditional device with rabbit ear antennae, no remote control, and perhaps in glorious black and white? It seems impossible to think that it was barely a decade ago most of the technology case managers currently struggle to master were but sparks in their respective inventor's eye.

A vast array of issues with global societal impact have potential to influence a case manager's individual practice. Not only do new issues appear daily but also bring unique acronyms. The latest in our health care industry include the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA), accountable care organizations (ACO's),

health information exchanges (HIE's) not to be confused with health insurance exchanges (HIX) and of course HIPAA (not HIPPA) with all of its renderings. Included are meaningful use (MU), business associate agreements (BAA), computerized physician order entry (CPOE), clinical decision support tools (CDST), and saving one of the best for last, lest we forget the implications of the nurse licensure compact (NLC) and the array of credentials to define a social worker's scope of practice which are not all created equal across states; that clinical licensure may be represented by LCSW (Licensed Clinical Social Worker), LCSW-C (Licensed Certified Social Worker-Clinical), or LICSW (Licensed Independent Clinical Social Worker).

Health and human service professionals, case managers among them, must rapidly act to ensure their proficiency across the board with whatever societal factors manifest, each poised to support and advance a case manager's ability to see the big picture of professional practice in high definition.

The key elements of the big-picture orientation competency include the following.

Bio-Psycho-Social-Spiritual Assessment

Case managers possess expanded power by assessing patients through the largest lens possible. Generations of social work professionals have had their practice grounded by learning how to assess the human behavior of patients through a bio-psycho-social-spiritual framing. Viewed collectively, the distinct realms of the biophysical, psychological, sociological, and spiritual dimensions provide a fundamental template to ensure a thorough and comprehensive evaluation of vital patient clinical pathophysiology and psychopathology. Ashford and Lecroy (2013) state, "Practitioners must be clear about how they will systematically assess, measure, or describe the characteristics of their clients and their various life troubles in the changing social and physical contexts." (p. 18).

A case manager's interventions are only as solid as his or her preliminary assessment, whether that assessment involves a patient or administrative or programming decision. Case managers must possess confidence in their knowledge about each individual patient in the unique circumstances of their illness course. This is a constant in case management and independent of one's practice setting and/or professional discipline of origin. It is integral to all professional disciplines that are involved in today's efforts toward high-quality care coordination.

From the COLLABORATE[®] perspective, it is an asset for case managers to engage a *Global Assessment Lens*[®], to be proactive, as opposed to reactive, in their efforts. This concept includes a multidimensional assessment, which is shown in Table 5.

TABLE 5
The Global Assessment Lens[®]

Biophysical	Psychological	Sociological	Spiritual
<ul style="list-style-type: none"> • Clinical acuity • Pathophysiology • Treatment protocols • Treatment plan variances • Disability accommodation • Key treatment history and concerns 	<ul style="list-style-type: none"> • Psychopathology • Cognition and mentation <ul style="list-style-type: none"> –Competence • Communication patterns <ul style="list-style-type: none"> –Listening skills and/or translation needs –Health literacy • Disability accommodation • Developmental stages • Psychosocial stressors • Risk of suicidal/homicidal ideation and/or intent 	<ul style="list-style-type: none"> • Family and Support system <ul style="list-style-type: none"> –Dynamics among involved parties and systems –Cultural influences, values, beliefs, and mores • Geographic and/or regional influences • Generational factors • Socioeconomic factors • Occupational system <ul style="list-style-type: none"> –Insurance –Entitlement eligibility • Government system <ul style="list-style-type: none"> –Legislation –Policies and procedures 	<ul style="list-style-type: none"> • Religion • Values, beliefs, mores • Individual philosophical grounding

This template is applicable to and may be adjusted to any patient, in any practice setting across all transitions of care. A Global Assessment Lens[®] is an asset, particularly where there continues to be various case management models involving a diverse range of professionals. Defined templates also support a case manager’s ability to track outcomes, which will be focused on in Part III of this journey.

Macro Impact on Micro Interventions

Macro impact signifies those larger-scale policy implications, also known as the view from 30,000 feet. Although the acronyms listed earlier in this competency were done with humor, each is poised to greatly influence a case manager’s micro or direct interventions. This involves any aspect of a case manager’s role and associated functions, from quality of and access to appropriate patient care to assessing and intervening with patients across state lines to the lack of ability to obtain authorization for behavioral health care despite the presence of a benefit for it. It behooves each case manager to stay away of current policy initiatives at the broad stroke, societal level which impacts their practice, and potentially their patient population.

In this COLLABORATE[®], the case managers engage in several efforts across personal and professional realms to ensure their awareness of and education about the current regulations that impact their licensure and their case management certification:

- Their calendar alerts them, whether smartphone or traditional date book, of a quarterly need to review the home page of their professional board to all that is under the “what’s new” section. This has become an increasing industry standard for a majority of professional boards across disciplines.

- Upon receipt of the professional organization magazine, they review for articles on relevant legislation and initiatives, defining when the article will be read.
- They join a social media group where there are active discussions about managing new policies, regulations etc.
- They form a peer-mentoring group at work to conduct monthly dialogues with colleagues about how macro issues in the workplace impact their individual practice, such as Affordable Care Act or licensure portability.

ORGANIZED

Key elements:

- Efficiency
- Effectiveness

Organize, don’t agonize.

—Nancy Pelosi

An idea can only become a reality once it is broken down into organized, actionable elements.

—Scott Belsky

Being organized certainly includes maintaining order in one’s workspace or getting to meetings on time or readily finding important information. Being organized is influenced by one’s skill, knowledge, experience, and aptitude. It requires a process, a mindset, and a level of flexibility that enables one to effectively deal with the curveballs of unpredictability that are unavoidable in real life. For the professional case manager, being organized requires objective consideration of actual and potential influencers, elimination of personal bias, and weighing the benefits and risks of available options. It also includes disregarding convenience or expediency

as overriding concerns to obtain an optimal client outcome.

Working in an organized way requires one to be both efficient and effective. These are highly desirable and coveted attributes. However, although “strong organizational skills” is an attribute frequently cited in position descriptions, precisely how one becomes organized or works in an organized manner is not a distinct topic of formal education. In addition, the objective measurement of organizational skill is not a routine part of preemployment screening, and process measures of performance lack direct correlation to actual effective case management performance. In reality, it is easy to claim to be organized and to spout off working according to urgency or other seemingly objective gauge. However, the demonstration of such an assertion is difficult to prove with any degree of certainty on the basis of traditional process metrics and near impossible to demonstrate as part of the typical hiring process. Hence, demonstrating one’s organizational skill is often placed within the domain of the performance evaluation. Measurement of such abilities is indirect and/or subjective in the absence of time-function studies or some other more traditional administrative metric that is a process metric rather than actually reflective of the outcome of case management intervention.

As Fetterolf (2010) noted, “Case management programs are materially different from standard medical management or disease management programs in a number of ways. The patients have complex medical conditions combined with many other variables that tend to increase their costs and patterns of utilization” (p. 73). He goes on to highlight that the variations encountered in case management practice setting, population served, and experience level make it difficult to define the value of case management at both individual and program levels. It is the lack of specificity that contributes to the difficulties in determining meaningful performance measures for case management on the whole, let alone achieving a degree of consensus as to how case management impacts the populations served in clinical and economic terms. Part of this dilemma goes back to the misuse of the “case manager” job title, which results in comparison of apples and oranges. Going forward, it is strongly recommended that all research pertaining to the value and/or outcomes associated with case management interventions contain detailed information as to the studied participants’ job (e.g., title, position description, scope of responsibilities, education level, qualifications, functions outside research scope).

To address the organized competency, it is essential to agree with the COLLABORATE® premise that

where an individual is concerned, the key elements to the skill are efficiency and effectiveness.

Efficiency

An organized case manager balances practice standards, regulatory and legal mandates, and organization-specific administrative constructs to provide services in a manner where effort expended results in optimal outcomes without unnecessary waste (e.g., expense, resource, time).

COLLABORATE® focuses on the development of meaningful case management metrics that contribute to strategic goals and are incorporated into a wide variety of documentation (e.g., job description, performance management program, department goals). Measures are tailored to focus on individual and department outcomes and used for peer-to-peer comparison in an effort to create an equitable compensation and rewards system that values performance over longevity.

Effectiveness

An organized case manager uses evidence-based interventions and tools as integral to the performance and remains flexible enough to accommodate the unexpected demands of day-to-day events to achieve desired outcomes (e.g., client objectives, program goals). For instance, an effective case manager is knowledgeable of best practices and utilizes interventions that have been shown to contribute to positive results, sharing this knowledge with his or her peers to improve consistency.

COLLABORATE® encourages the use of evidence-based guidelines to develop measurable case management interventions and improve consistency of team-wide service delivery and outcomes (e.g., adherence rate, biometric measures, utilization). This is subsequently incorporated into case management-specific documentation (e.g., performance expectations, job description).

RESOURCE AWARENESS

Key elements:

- Utilization management
- Condition/population-specificity
- Management of expectations per setting

You cannot afford to wait for perfect conditions. Goal setting is often a matter of balancing timing against available resources. Opportunities are easily lost while waiting for perfect conditions.

—Gary Ryan Blair

For the overwhelming majority of health care consumers, resources are limited; however, health care resources continue to be spent on interventions that are of little benefit or are even harmful (Sirovich, Gottlieb, Welch, & Fisher, 2006, p. 641). There is a wide variation in the utilization of health care resources across the United States. Studies demonstrate that quality of care, access to care, and patient satisfaction are not better in regions where more resources are spent (Fisher, Wennberg, Stukel, Gottlieb, & Lucas, 2003, p. E294; Sirovich et al., 2006, p. 646).

So how do these findings translate to impact case management practice? Simply put, it is very often a case manager (e.g., care coordinators, nurse navigators) who reviews, authorizes, coordinates, and/or intervenes at some point of the transaction to ensure that the client obtains the ordered test, product, or service. An accurate volume of health care goods and services that cross a case manager's path from the point of order to delivery each day may not be quantifiable, but this requires further study to better understand the volume impact that case management has on health care delivery. For the purpose of this article, it is sufficient to recognize that, because of the influence case management has on care delivery, it is essential for the professional case manager to have an awareness of available resources and objective methodologies for fair and appropriate decision-making related to resource utilization.

It is inappropriate for a case manager to foster client expectations that health insurance covers all products and services, but rather he or she should explain the existing benefits, critically analyze the situation to identify options and alternatives, and advocate on behalf of the client needs to produce an optimal solution. Failure to take a methodical approach often leads to a number of unnecessary and

Advocacy, on behalf of a client, for a product or service that is not covered by health insurance is a function of case management. This is most effective when the case manager is knowledgeable about the evidence related to a product or service and is able to articulate the anticipated benefit(s), as well as the possible risk(s), to the care team to gain consensus for the best outcome of the client.

unproductive dynamics in care transitions (see amplification in Table 6), such as the following:

- Client disappointment and frustration
- Perception of good versus evil
- Pits case managers against each other

Advocacy, on behalf of a client, for a product or service that is not covered by health insurance is a function of case management. This is most effective when the case manager is knowledgeable about the evidence related to a product or service and is able to articulate the anticipated benefit(s), as well as the possible risk(s), to the care team to gain consensus for the best outcome of the client.

Consider the following scenario and how resource awareness becomes critical to transition planning. From the day of admission, an acute hospital case manager has been working with a 62-year-old gentleman admitted following a cerebral vascular accident (left-sided) that occurred at home. The

TABLE 6
Pitfalls of Mismanaged Expectations

Risk Area	Failure	Success
Client disappointment and frustration	Failure to provide explanation of existing health care benefits for post-acute care leading to client and caregiver upheaval when determination is not aligned with their demanded outcome.	Ensuring that client and caregiver understand the healthcare coverage and limitations before discussing transition plan options.
Perception of good versus evil	Failure of care team communication leading to confusion, poor execution of transition plan, and blaming/scapegoating a colleague as the "bad guy."	Taking a personalized approach to care planning that includes a discussion (and documentation) of available options. This fosters unified messaging across the care team.
Pits case managers against each other	Placing the blame for denied level of service authorization with the insurance company.	Clear explanation of benefit and authorization process leading to collaborative transition plan compromise.

effects of this stroke require physical, occupational, and speech therapies. The client's wife has demanded that he be transferred to an acute rehabilitation hospital and has been unwilling to discuss sending him to what she considers to be a "nursing home." At the present time, the client is not physically able to participate in more than an hour of combined daily therapy each day. The case manager contacts the client's insurance company to determine insurance coverage (e.g., deductible, copayment, coinsurance), in-network postacute facilities, and authorization criteria for admission to various levels of care.

Utilization Management

The resource-aware case manager considers all aspects of a situation when developing recommendations for utilization of available resources, consulting with relevant care team members, and understanding the benefits and risks associated with each option before proposing case management plan interventions. Mindfulness of available resources and advocacy for their appropriate use focuses on what is best to address the needs of each client.

Using the COLLABORATE[®] approach in the aforementioned scenario, the case manager proposes a phased approach for the transition plan, beginning with an admission to a skilled nursing facility. The proposal includes milestone goals that trigger level of care reevaluation and *possible* transfer to an acute rehabilitation facility. This approach is supported by the attending provider and care team members, including the insurance company. At a face-to-face meeting with the client and his wife, the case manager explains the rationale for this tactic in terms of maximizing available health care benefits within the client's current physical abilities. The case manager emphasizes that sufficient improvement could be realized by an interim skilled nursing facility admission, making a subsequent rehabilitation admission more productive or perhaps unnecessary. It is also made clear that this approach reduces (but does not entirely eliminate) the risk for delays in care transi-

tion to the most appropriate facility and also minimizes their out-of-pocket expenditure relating to their plan's copayment and coinsurance amounts.

Condition/Population-Specificity

The resource-aware case manager maintains current knowledge of health conditions, insurance coverage, community resources, and care criteria sets to prepare realistic and responsible case management plan to meet the client's individual needs.

The COLLABORATE[®] perspective is highlighted when a client diagnosed with chronic obstructive pulmonary disease is ready for hospital discharge following an acute exacerbation. The client's primary care provider prefers that his patient returns home and returns to her outpatient pulmonary clinic, which includes condition-specific educational sessions and clinic-based case management services. After discussing options with the client, it is learned that he does not have reliable transportation to get to and from the clinic and is concerned that once he returns to work, he will not be able to get the time off for the clinic appointments. Conversation at the care team meeting identifies alternatives and the transition plan proposes the following options, presented in Table 7.

Management of Expectations Per Setting

The resource-aware case manager understands that setting and managing client expectations from the point of initial contact facilitate subsequent interactions and contributes to building a trust-based relationship. This is best accomplished through understanding the complexity of influencing factors related to care management. Framing expectations that align with these dynamics is accomplished through clear, accurate, and objective communication. Failing to manage expectations risks a suboptimal outcome, including but not limited to, low client satisfaction and care delays. In transition of care situations, it sets the stage of forcing a poor choice for location of care, which risks the client's condition and possibility of readmission.

TABLE 7
Transition of Care Options

Option 1	Option 2	Option 3
Transition to home with visiting nurse agency services for physical reconditioning, energy management strategies, and nutrition support to rebuild strength before enrollment in the outpatient clinic program. This option is likely to be approved by his health insurance plan on the basis of severity of illness and intensity of service criteria.	Transition to a skilled nursing facility for short-term therapies and nutrition support before returning home with visiting nurse agency services and subsequent enrollment in the outpatient clinic program. This option is likely to be approved by his health insurance plan on the basis of severity of illness and intensity of service criteria.	Transition to an inpatient pulmonary rehabilitation program for therapies, nutrition support, and condition education. This option requires a benefit exception request from his health insurance plan.

COLLABORATE® encourages the case manager to work with the client and caregiver to clearly communicate the facts and likely process steps. In the scenario described earlier, the client's wife demanded acute rehabilitation hospital placement, but the client's condition was such that he was not able to participate in the amount of daily therapy required to qualify for that level of care. The case manager took a thoughtful approach to explaining the client's insurance coverage and how the level of care is determined to manage expectations of what was reasonable and most suitable for the transition plan. In addition, nearby in-network skilled nursing facilities screeners were called to the hospital to introduce their respective facilities and available services. After visiting the facilities, the wife had a better understanding of the available options for care and verbalized an increased comfort level with a skilled nursing facility discharge.

ANTICIPATORY

Key elements:

- Forward thinking (professionalism)
- Proactive versus reactive (care strategy)
- Self-directed (professional autonomy)

Wisdom consists of the anticipation of consequences.

—Norman Cousins

The frustrating thing about the future is that, just as you reach it, it slips away and into the distance, making its true form hard to determine and the task of embracing it a difficult one.

—Daniel Allen

To anticipate means that one takes measures to prevent, mitigate, or otherwise nullify the possible harms of a predictable outcome to realize a more positive result. This does not mean to imply that one jumps into the middle of a situation and takes control but rather takes a circumspect approach to considering and offering educated, evidence-based, and well-informed recommendations to optimize a positive result or minimize a downside impact or outcome. In case management, the desired goal is to use education, experience, CT, and clinical judgment to assess a client's status and weigh the risks for experiencing untoward outcomes. On the basis of that analysis, the case manager is able to work with the client/caregiver and care team to activate measures aimed to avoid or appreciably reduce those negative consequences.

Anticipatory interventions have supposedly been a part of the case management value equation for decades. But perhaps there is a variance worth

some consideration. In 2011, anticipatory care was identified as an *emerging* topic in nursing literature. It was defined as working with clients to identify any circumstances that may have a negative impact on their mental, physical, and social health and to put in place proactive strategies to avert those impacts (Kennedy, Harbison, Mahoney, Jarvis, & Veitch, 2011, p. 1559; Kralik, 2011, p. 1407). Doesn't this sound eerily familiar to what *professional case managers* have been doing for decades? Case management has long sought recognition for addressing existing care challenges, for proactive identification of care barriers, and for creating and activating plans that mitigate, if not prevent, their furtherance. There are a few questions as to why anticipatory care was deemed to be a new concept.

- Could it be a matter of semantics that the authors defined the meaning of care as being specific to hands-on direct patient care in the historic sense?
- Is this an author inference that case management is not considered a nursing or care function?
- Perhaps this is an indication that anticipatory care, although an assumed case management skill has not been clearly articulated in literature or proven in actual outcomes?

Uncovering these references raises questions as to whether case management practice should be more specific in terms of documenting the function of anticipating and highlighting situational risks associated with the care of the client. A cursory survey of three documents pertaining to case/care management practice standards and one code of conduct by using the terms *anticipate*, *anticipatory*, and *proactive* indicates that this may not be as well-articulated an expectation as it has been believed to or should be. If proactivity and/or anticipatory care are supposed to be a characteristic of professional case management, this indicates a need for further evaluation and clarification in foundational case management documentation.

In the COLLABORATE® paradigm, key elements of this competency include the following.

Forward Thinking (Professionalism)

The forward-thinking case manager takes into consideration immediate as well as future implications of his or her actions and interventions. For instance, a forward-thinking case manager actively engages on a public policy committee to advocate for multistate licensure policy. This individual realizes that his or her contribution is essential to advancing case management through reduction of artificial barriers to practice.

Proactive (vs. Reactive) Care Strategy

The professional case manager embodies proactivity by developing and implementing client-centered interventions that address existing barriers to care and also include risk mitigation strategies that stem the tide on reasonably foreseeable challenges. Where care facilitation is concerned, anticipation is mentioned within the following practice standards:

- Facilitation, coordination, collaboration (CMSA, 2009, p. 18)
- Facilitation (American Case Management Association, 2007, p. 8)
- Assessment (NASW, 2013, p. 30)
- Service planning, implementation, monitoring (NASW, 2013a, p. 34)

The COLLABORATE® paradigm highlights the proactive attitude as a hallmark of a professional case manager, focusing on prevention and mitigation strategies that highlight their value to the health care team. For instance, a client mentions that the sister who drives him to all health care appointments is moving out of state next month. Instead of waiting for the client to miss an appointment, the case manager helps the client identify other transportation resources, facilitates arrangements for upcoming appointments, and initiates home delivery of prescriptions and groceries to alleviate additional transportation demands.

Self-Directed (Professional Autonomy)

COLLABORATE® defines self-directed practice in terms of functional autonomy to practice independently within the scope of one's professional practice act and/or other accepted limits (e.g., legislation, regulation, certification, organization). The self-directed case manager maintains a collaborative yet independent approach to practice. This is evidenced in the performance of responsibilities without the necessity of prompting by another care team member.

Defining self-directed practice (professional autonomy) for case management requires serious attention. There are many variables in play that go far beyond the scope of this article. However, meaningful discussion and research are required to ensure comprehensive understanding from the perspectives of all stakeholders. The determination of case management's continued growth and development must be a collaborative undertaking.

A few of the confounding factors affecting professional autonomy are independent practice recognition, professional affiliation, and state of licensure. There are many independent case management companies that contract with labor unions, states, medical practices, insurance providers, as well as direct-to-

client to provide complex case management services. Within nursing and social work, the dominant professional affiliations feeding into case management, autonomy, and control over practice have been developed and debated for years. Key issues in the discussion of nursing include Weston (2008, p. 404), who sought to clarify and delineate the definition of control over nursing practice versus autonomy, and Skår (2008, p. 2226), who focused on the defining concepts of nurse autonomy (e.g., authority of total patient care, the power to make decisions, the freedom to make clinical judgments). For social work, the issues of licensure, education level, and scope of practice vary from state to state and are ongoing matters of concern, similar to nursing. The topic of case management certification also adds a layer of complexity to the discussion.

The issue of professional autonomy extends well beyond the scope of a particular practice model to address, let alone to resolve. Because of the issues that need to be incorporated in any productive discussion, as well as inclusion of consumer confidence and protection, the COLLABORATE® model heartily encourages key case management stakeholders to undertake an organized and unified approach for developing consensus as to the definition and intent of professional autonomy where case management is concerned.

TRANSDISCIPLINARY

Key elements:

- Transcending
 - Professional disciplines
 - Across teams
 - Across the continuum

Coming together is a beginning. Keeping together is progress. Working together is success.

—Henry Ford

None of us is as smart as all of us.

—Ken Blanchard

Countless articles have been written over the past several decades to address the value of diverse professional expertise comprising the health care team. A rich historical foundation, which also addressed case management's alignment with this effort, was discussed in Part I (Treiger & Fink-Samnack, 2013).

Those of you with longevity in our case management industry may have experienced these team types identified in *The Free Dictionary* (n.d.). Each begins from the premise of a team as a group of people or units organized to do a task together.

This evolution of team types may look familiar to most, though note the creative revision.

- *Multidisciplinary*: This team of professionals includes representatives of different disciplines who coordinate the contributions of each profession, which are not considered to overlap, to improve patient care. They may continue to be somewhat siloed as each team member focuses on his or her unique scope of care. *A majority of Pokeys™ and few, if any, Gumbys™.*
- *Interdisciplinary*: A group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient. There is increased communication and collaboration among team members. *A growing majority of Gumbys™ though a strong minority of Pokeys™ may obstruct the process from time to time.*
- *Transdisciplinary*: A team composed of members of a number of different professions cooperating across disciplines to improve patient care through practice or research. *100% GUMBY™ CONSENSUS: NO POKEYS™ ALLOWED!*

Transdisciplinary expertise within teams presents as the optimal means to address the scope of obstacles that have emerged on health care's horizon. The increased number of facilities seeking Magnet accreditation is cited specifically as a key motivator for evidence-based transdisciplinary team expertise (Satterfield et al., 2009).

The point loudly resonates through the emergence of ACOs, mandating the collaboration of a group of providers and suppliers of services, including the hospitals, physicians, and others involved to coordinate care for the patients they serve with original Medicare. They are to be true partners in care decisions (Healthcare.gov, 2013). There have been early naysayers of ACOs who pondered why any level of legislative mandate was necessary to ensure that care be rendered in an accountable manner. One would expect that both the organizations and its professionals tasked with providing care be accountable for the highest quality of practice by virtue of regulations, licensure, and the like. Let us not cloud the issue with logic. Perhaps a question to consider is: do ACOs serve as a proxy for the population's need for transdisciplinary teams?

The increased cost of health care continues as a fiscal priority for all stakeholders, serving as yet another factor that begs for transdisciplinary team involvement. Health expenditures in the United States alone neared \$2.6 trillion in 2010, more than 10 times the \$256 billion spent in 1980. Of these national health expenditures, 75% alone has been related to chronic disease treatment (KaiserEDU.org, 2013). This adds further fuel to the fire for optimal means to appropriately manage health care's processes, treatments, and accompanying interventions.

Communication challenges across the continuum of care are another compelling factor. Poor communication processes manifesting across care settings with their often fragmented and siloed approaches to care have a negative impact on the quality of care (Treiger & Lattimer, 2011). Focus on the nature, quality, and frequency of team communication has become even more heightened in our global society. Patients now access care across settings regionally, nationally, and internationally. Communication about patients occurs through various modes, from the traditional in-person, telephone, and e-mail to more complex encrypted electronic health records and patient portals. The HIPAA Final Rule mandates that by January 2014, covered entities are required to have end-user devices encrypt by default plus that hospitals and physicians provide patients with access to their health records through portals (Office of the Federal Register, 2013).

Telehealth, telemedicine, and remote health monitoring continue to maintain their popularity and expansion. At the time of this writing, the National Council of State Legislatures website showed 42 states providing some form of Medicaid reimbursement for telehealth services. Fifteen states have private insurance requirements in place (National Conference of State Legislatures, 2013), with the number expanding. Licensure portability challenges and the inconsistency of professional regulations continue to serve as further obstacles to the maximum utilization of these new modes of health care intervention. Regulations being out of sync with practice reality negate the ability of professionals to consistently and appropriately render intervention across state lines and cyberspace (Fink-Samnack, 2012a).

It is an essential underpinning for COLLABORATE[®] that the key elements of the transdisciplinary competency be viewed as transcending across all areas noted. As a result, this fluid flow is demonstrated through a comprehensive framing of the key elements as follows.

Transcending Professional Disciplines, Teams, and the Continuum

The importance of grounding the value of the competencies underlying health care's professional practice disciplines is discussed in Part I. These competencies set the cornerstones for our individual practice, reinforced through education, training, licensure, and/or other regulatory, and organizational framings. Health care quality is a comprehensive and consolidated team effort, which is interprofessional, and thus transdisciplinary in scope (Treiger & Fink-Samnack, 2013).

Transdisciplinary teams ground by the integration of a concept called *Professional Diversity*[®], fully

detailed in Table 8. Moving forward from those points defined by the Institute of Medicine and Inter-professional Education Collaborative documents cited in Part I of COLLABORATE[®], Professional Diversity[®] sets a context and standard by which health care teams should function.

Consider this case scenario which is addressed from the COLLABORATE[®] perspective and covering each of this competency's elements. Mr. Janus is a 56-year-old married man admitted from his home for the third hospitalization in as many months for pneumonia and respiratory failure. With a diagnosis of amyotrophic lateral sclerosis, he is alert, fully oriented, and competent to make his own medical decisions. He communicates through mouthing words and a picture board. Mr. Janus has a "do not resuscitate" order, is totally dependent for all activities of daily living on continuous trach collar at 40% oxygenation and parenteral nutrition. His spouse is on family medical leave to provide care. The couple requests the hospital transdisciplinary team to coordinate a discharge plan involving Mr. Janus's transition to his apartment in Florida, where he can die looking out at the ocean. Mrs. Janus will drive their van for 14 hours.

The managed care case manager recommends patient transition to a nursing home with hospice, over the next 48 hours. As the case manager, you challenge the team to define what Mr. Janus requires to implement a safe plan. You instruct them, "Don't

think about what can't be done here, but rather what is needed to make this work." The following objectives are identified:

1. Private hire of a nurse capable of rendering respiratory care, including suctioning, monitoring of his parenteral feedings, and all identified activities of daily living. This nurse will demonstrate competence to render care to patient care coordinator for the team.
2. Coordinate with the durable medical equipment provider for appropriate oxygen and supplies for the trip plus safe securing the tanks in the vehicle. A list will be provided of all durable medical equipment and supplies, with assurance of delivery and set up of items before the patient's discharge.
3. Dialogue between the patient's attending physician and primary physician in Florida to ensure care needs discussed, with discharge summary provided. All medications will be called into the pharmacy in Florida, which also does delivery. The patient's primary physician in Florida will complete the referral to hospice and coordinate with them directly to ensure that all orders are completed.
4. Maximum implementation time frame: 72 hrs.

Everyone is notified and approves the plan, which is implemented with 48 hours. Mrs. Janus contacted the hospital case manager upon their arrival in Florida to say they arrived safely, 14 hours following their departure from hospital. She called again 2 weeks later and left the following message. "Please thank the entire team for helping to make these last few weeks so peaceful. Mr. Janus died over the weekend, but his last view was of the ocean and the sunset, as he had requested."

TABLE 8

Professional Diversity[®]

Definition:

The collective synergy of health and human service discipline-specific competencies utilized to enhance care coordination.

The Concept is:

- a foundation of all case management practice
- transdisciplinary in application
- transcends traditional professional boundaries
- patient-centered in scope
- applicable across transitions of care (Fink-Samnick, 2012b)

The concept promotes:

- approaching patient situations by involved team members, orienting to the needs of the person as opposed to the context of a specific discipline or expertise
- the ability of the entire team to develop workable solutions by reaching across perceived boundaries of respective professional disciplines to:
 - communicate openly
 - share insight
 - form strategic partnerships, and
 - identify resources through open dialogues
- mutual respect as an underlying theme (Fink-Samnick, 2010)

ETHICAL–LEGAL

Key elements:

- Licensure
- Certification
- Administrative and professional standards
- Organizational policies and procedures
- Ethical codes of conduct

Law is a framework of authority directed by Ethics.

—Lynn S. Muller

Some of you might suggest that it is a "best for last" rationale that positions the ethical–legal competency for the finale. Perhaps that would reveal a tad bit of professional bias. The truth is this competency presents in COLLABORATE[®] at this juncture solely because of the acronym order. The paramount

importance for case management of a united ethical–legal perspective is undisputed. Is this yet another example of clouding an issue with logic?

Ethical and legal issues are in a synergistic relationship, both with tremendous potential to impact a case manager's interventions. One hears the term legal and his or her brain embarks on a lengthy journey to a long list of destinations from litigation or suit to malpractice and subpoenas. They may consider adherence to laws and regulations specific to their employer, a patient, or potentially scope of their professional practice. Legal could mean focus on contracts or business associate agreements, a common concern in this age of innovation.

Ethics refers to the analysis of principles, rules, or language that characterize an action or judgment bearing on human welfare as right or good or wrong, harmful, evil, beneficial, burdensome, etc. (Beauchamp & Childress, in Powell & Tahan, 2008, p. 597). It has a wide berth of directions from professional ethics to bioethics. Both play a critical role in our ethical grounding. Professional ethics encompass personal and corporate standards of behavior expected (Chadwick, 1998). Case managers may identify these as autonomy, nonmaleficence, beneficence, and justice (Banja, 2008). Bioethics involves the philosophical implications of certain biological and medical procedures, technologies, and treatments as organ transplants, genetic engineering, and care of the terminally ill (Bioethics, 2012). Ethics is far from what is black and white, but rather all that is gray, pink, purple, and every other color of the rainbow.

Space does not permit a full list all of the individual ethical and legal standards and/or codes. However, it is suffice to say that most, if not all, of the professional associations include related content. Each one of these is specific in framing the parameters for ethical and legal adherence with respect to one's professional discipline of origin (i.e., nursing, social work, medicine).

One may be inclined to prioritize legal concerns over ethical concerns. The laws related to practicing outside of the scope of a license have potential equally dramatic ethical implications, such as misrepresenting credentials or not advocating appropriately for a patient. Both may prompt sanction, legal from a warning to revoking of licensure, ethical could involve equal sanction from a certification entity and ultimately loss of a credential. Common threads present amid so very many ethical and legal situations.

Although ethical practice may be viewed as more philosophical and subjective in interpretation, why view it totally separately from its more defined and rigid legal partner? Imagine the power of a combined competency that mandates equal attention to both areas. It is not uncommon for a case manager

to analyze the legal implications of his or her practice and ignore the ethics and vice versa. Particularly in our litigious society, case managers are concerned with ethical–legal conflict in which they want to provide quality case management services (Muller, 2008).

The key elements of the ethical–legal competency include diligence with and adherence to the following: *Licensure, certification, administrative and professional standards, organizational policies and procedures, and ethical codes of conduct.*

The COLLABORATE® perspective is especially beneficial in this multifaceted situation. As the case manager for a large regional managed care organization, you are excited about a new grant through The Federal Communications Commission Connect. This is a model integrated behavioral health pilot project expected to expand nationally. Your understanding is that it will expand telemedicine and telehealth in your region, ensuring greater access for patients in rural areas to the high-quality health and mental health care they might not otherwise receive.

In a meeting to frame the program, you are informed how all of the patients in the program have been diagnosed with both a mental disorder and a series of chronic medical conditions. It is also shared that patients may potentially reside across the surrounding tristate area. You know that one of these states is member of the nurse licensure compact but the other is definitely not.

You raise your hand to ask several questions. As you present a concern about practicing across state lines, you are told by the medical director, "This is no biggie. Your interactions are not considered assessing, but merely follow-up contacts." You could not disagree more. Having made follow-up calls in the past, you are quite familiar with what happens when you get a patient on the phone.

It does not take long for your fears to be realized as the situation becomes more convoluted than one could ever imagine. It begins when you contact the first name on the list. What started as a simple "follow-up" has you suddenly assessing a patient across state lines in a state where you are not licensed, with the patient potentially at risk of suicidal ideation and homicidal intent. Ethical and legal issues are tangled and quite intertwined. It becomes tough to see where one ends and the other begins, but your journey to unravel this tangled mess begins.

Licensure

You are a case manager in the know and aware that there is NO mandated duty to report statute in your state. You are surprised but have scoured the administrative practice laws and called the board of nursing to verify it. You are confident that the code of

ethics, which underlies your profession, is clear with respect to your duty to report a patient who is at risk of harming himself or others. As a result, you contact law enforcement immediately.

Certification

You contact the organization that provides your certification to request an advisory opinion. They are supportive, guiding you to the appropriate place in their code of ethics and professional conduct to support your decision to adhere with duty to warn.

You then take this opportunity to discuss your new role and whether the situation you just engaged in involved assessment, one of your primary concerns about the role. It is suggested that potentially you performed an assessment in this situation. As a result, it is recommended you contact the board of nursing in your home state for further guidance and direction. It is also advised that you review your scope of practice with the state board regarding telemedicine and telehealth regulations. New administrative regulations are being developed and revised swiftly to this end and it is best practice to review these updates at least every quarter, if not more frequently. There was further dialogue about exploring how current your organizational policies and procedures are to this end.

Administrative and Professional Standards

You are a case manager with a mission and work to collect all the evidence you can to discuss this matter further with your director plus the medical director. Serious advocacy is needed to address the interplay of potentially practicing against ethical codes, as well as illegally. It is your license and your certification plus those hard-earned letters after your name. You print out a copy of the ethics and legal professional standards. All are clear in their language that you are beholden to:

1. Behave and practice ethically, adhering to the tenets of the code of ethics that underlies your professional credential, and
2. Adhere to applicable local, state, and federal laws as employer policies, governing all aspects of case management practice, including client privacy and confidentiality rights. It is the responsibility of the case manager to work within the scope of his or her licensure (CMSA, 2010).

Organizational Policies and Procedures

It is time to do a serious review of these with your director. There is no mention of any of the recommendations provided to you by the experts. There must be new policies to reflect the current practice trends and make sure everyone knows the scope of

their practice to minimize liability or at least how to access the information. You strongly feel that the policy should include a listing of the URL for each state professional board, certification entity, and professional association. The section will be called ethical and legal parameters for practice.

Ethical Codes of Conduct

You are appreciative that the ethical codes across the assorted entities you are aligned with are as clear as they are. In fact, you see they are more similar than different. You consider how vital it is that there has been renewed appreciation for the important role these documents serve to ground professionals in their actions. Although ethics is not usually black and white, at least there is guidance to bring out to you the other side of the gray. You download the documents for nursing and case management, adding them to your stack of resources for inclusion in those new policies you will help write.

CONCLUSION

This article provides clarification of the COLLABORATE[®] competencies. This is our contribution and commitment to advancing case management practice as a true profession. We challenge the case management industry to commence serious, meaningful, and most importantly *collaborative* dialogue.

Implementation of the COLLABORATE[®] model, as with any quality improvement initiative, requires top-down organizational alignment in combination with the personal commitment of each person involved in the effort. Join us for the third and final part of this series as we examine performance management implications which should be addressed as part of operationalizing COLLABORATE[®]. Those who contend they are more a Pokey[™] than a Gumby[™] should begin to limber up now because having defined performance expectations inevitably leads to flexing and bending in directions you may not have thought possible.

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