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COLLABORATE©: A Universal Competency-Based Paradigm for Professional Case Management, Part I: Introduction, Historical Validation, and Competency Presentation

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ABSTRACT

Purpose/Objectives: The purpose of this first of a three-article series is to provide context and justification for a new paradigm of case management built upon a value-driven foundation that

- improves the patient's experience of health care delivery,
- provides consistency in approach 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 there will be 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 why the definition of a competency-based case management model's time has come, 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 by the competencies critical to successful practice and quality patient outcomes. This results in a fragmented professional case management identity. While there is 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, competency, health care, nursing, model, paradigm, return on investment, social work, transdisciplinary*

Case management has the social and human services sectors to thank as its origin. From the early 19th century and before government intervention, charitable organizations provided individuals in need with the supportive services of public health nurses and social workers. Although initial government efforts were fragmented, the Social Security Act of 1932 began the push to coordinate across various public assistance programs, creating the U.S. Social Security insurance program, which was supported by taxes applied on both individual wages and employer payroll rather than directly by the government. In addition to supporting the aged, this Act funded assistance initiatives for children, the blind, and the unemployed to provide vocational training and family health programs (Our Documents, 2012).

The next significant developments came in the 1940s when Liberty Mutual began to leverage case

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management strategies in an effort to control the cost of rehabilitation care for injured workers. Following World War II, returning injured soldiers whose catastrophic wartime injuries required an intensive, multidisciplinary treatment approach received care coordination support from nurses and social workers who were best qualified to provide oversight to their complex clinical care needs (Lowery, 2010, p. 4; Powell & Tahan, 2008).

In the 1960s, as insurance companies initiated programs focused on workers' compensation and return-to-work strategies, the Insurance Company of North America, which would eventually become CIGNA, launched a vocational rehabilitation program employing nurse case managers on the basis of the success of preceding programs (Powell & Tahan, 2008).

There were other influences that contributed to the growth of case management, such as Medicare and Medicaid demonstration projects, the deinstitutionalization of developmentally challenged individuals, and the Older Americans Act of 1978. Each of these efforts added social service coordination and medical case management for their respective populations with the intent being to encourage more community-based care (Powell & Tahan, 2008). The passage of the Health Maintenance Organization Act was arguably the most significant event affecting case management during the 1970s. With recognition of the need to contain spiraling health care costs, this expansion of the Public Health Service Act of 1944 spurred on the development of two strategies that were believed to be vital in controlling the escalation of health care costs. Utilization review, as a means to ensure that requested health care services were medically appropriate with regard to their setting and intensity of care, and case management that focused intensive coordination of care and benefit management on individuals consuming large-volume and/or high-cost health care services as a result of complex health care conditions or catastrophic injury (Powell & Tahan, 2008).

Subsequent decades witnessed the proliferation of case management programs across various health care settings. It is important to recognize that while these programs were referred to as case management, the actual functions and activities of staff were often not reflective of the full scope of case management practice. The case management department title, as well as the job title of case manager, was often misused as a blanket term for medical management strategies based, in part, to its name recognition. In retrospect, it appears that little attention was given to ensuring that the role and responsibility of case management jobs were true to the definition and full scope of actual case management practice as defined by the widely accepted Case Management Society of America's (CMSA's) Standards of Case Management Practice. These voluntary professional standards, first published in 1995 with subsequent major updates in 2002 and 2010, codified the role, function, activities, and standards for sound, professional case management practice across the entire health care continuum, irrespective of professional affiliation (e.g., nursing, social work), setting of practice, or certification status. While other standards were subsequently released, they have not been as consistently recognized or adopted due in part to their limited scope of professional affiliation, restricted applicability to a specific institutional setting (e.g., hospital-based, managed care), or focus on a particular segment of the patient population (e.g., geriatric).

As health care continued to evolve, "case management" departments focused their attention on utilization review and discharge planning. The use of evidence-based appropriateness criteria (e.g., McKesson Interqual, Milliman Care Guidelines) to evaluate service appropriateness, admission classification, and length of stay added to the bureaucratic burden of information exchange between provider offices, health care delivery institutions, and payers, all focused on justifying the medical necessity of services being requested or rendered. These administrative processes resulted in the consumption of an ever-increasing proportion of both administrative and clinical staff hours, as well as the investment into communication solutions (e.g., facsimile routing systems, telephone call centers). Attempts to distribute workload without adding cost resulted in the almost-constant shift of tasks among existing staff, as well as ongoing changes in organizational structure and job titles.

In the payer sector, contracts based on diagnostic-related groups and/or case rate were perceived as less risky, whereas per diem arrangements resulted in less-predictable care costs particularly in situations where individuals were not discharged in an efficient and timely manner because of social issues or other factors (e.g., availability of beds in less-intense settings of care). At some plans, the focus shifted to discharge planning and care coordination activities rather than daily concurrent review. These efforts were the

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precursors to more intense transition of care programs that began to appear in response to legislative, regulatory, and reimbursement changes instituted in the early 2000s.

Risk-sharing arrangements between providers and payers resulted in placement of payer-employed case managers within the walls of medical practices and hospitals. This was done to improve relationships with the provider community, allow face-to-face communication with patients, directly monitor utilization, coordinate health care services, and arrange social support services to encourage the safe and efficient delivery of care in the community setting. Occasionally, case managers followed members throughout the continuum of care, making visits to the hospital facility and/or other care settings to which the patient was admitted. However, the ability to maintain this work process was greatly dependent upon the proximity between the practice site and facility where each patient resided. Another influencer was the relationship between the major stakeholders (e.g., physician group, payor, health care facility). Barriers to optimal collaboration included case managers having limited or no direct access to patient care units, medical records, and/or attending providers. This significantly impacted the case manager's ability to assess, monitor, plan, and facilitate successful care coordination and transition plans.

These models of colocated case management also placed burdens on providers and hospitals to create a workspace for case managers that included telecommunication services and information system access. While some absorbed the cost of maintaining outside staff on campus, others established contracts that included financial arrangements to recover expenses. The effectiveness of case management programs in terms of cost savings, improved health care quality, better patient outcomes, and improved access to care has been neither widely quantified nor published. Another "unknown" was the influence these on-site case management models had on communication and collaboration between stakeholders and care team members.

Throughout the 20th century, efforts to coordinate care and control costs had been directed at utilization management of the patient-transaction level. This preceded the widespread implementation of condition-specific intervention programs. Early on, these initiatives were referred to as disease management and focused more attention on the population segment with chronic health conditions that had not yet begun a pattern of consistently high resource consumption, using statistical analysis and predictive modeling techniques. Program content included partnering with or establishing a relationship with the primary care provider, assessment and education specific to an individual's health condition, self-management, lifestyle change, appropriate utilization of health care resources, and medication adherence/persistence. In some situations, disease management programs resulted in the elimination of functions from the case manager's scope of responsibility: creating an entirely new layer of bureaucracy within the payer's medical management department.

The impact of tight utilization management, as an aspect of case management, on overall health care expenditure, improvement of care quality, health outcomes, or patient satisfaction rating may not ever be clearly or universally demonstrated. However well-intended these early collaborative efforts were supposed to be, in the absence of meaningful financial incentives built into provider reimbursement methodologies that encourage behavior and/or practice pattern change, opportunities to improve collaboration and coordination of care across the care team lacked a level of enthusiasm or acceptance sufficient to sustain them on a widespread, long-term basis.

As the 21st century continues, the single most significant impact on health care to date has been the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010. This sweeping legislation is yet another expansion of the Public Health Service Act. The focus of PPACA is to decrease the number of uninsured Americans, reduce the overall costs of health care, and improve the quality of care through a variety of institutional and individual mandates and financial incentives, which progressively go into effect over a period of 10 years from 2010 to 2020. Ultimately, reforms are intended to improve health care outcomes and streamline care delivery. Key initiatives affecting case management have been and will continue to rollout through 2013. Some of these impact areas are noted in Table 1.

Current Influences on Case Management Practice

Key Health Care Reports

Case management roles and functions have been recognized in numerous governmental reports focused on health care quality, as well as cited as a means to enact needed changes in the delivery of health care within the United States. While not consistently referred to as case management, the mandate for accountability and improvement in care coordination has been noted to be instrumental for the improvement of health care safety and quality.

The Quality of Health Care in America Committee was formed in June 1998 at the Institutes of Medicine (IOM). Its charge was to develop a blueprint for quality improvement in the delivery of health care. The recognition of compromised patient safety in the

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TABLE 1
Key PPACA Milestones With Impact on Case Management

Date	Event	Impact
2010	Coordination of care for dual eligible	Coverage eligibility, Benefit coordination
	Preexisting conditions	Coverage eligibility
	Consumer-focused website	Educational resource
	Expansion of 340B	Pharmacy coverage
	Adult-dependent coverage	Coverage eligibility, Benefit coordination
	Consumer appeal process for benefit determinations	Coverage determination, Educational resource
	Preventative benefit coverage	Coverage eligibility
	Medicaid community-based services	Benefit coordination
2011	Medical loss ratio minimums	Department budget, organizational structure, Reorganization, Job description
	Medicare Part D coverage gap	Pharmacy coverage
	Creation of Center for Medicare and Medicaid Innovation	Career opportunities
	Medicaid Health Homes	Career opportunities
	Medicaid Chronic Disease Prevention Programs	Career opportunities
	Medicaid Long-Term Care Services	Coverage eligibility, Benefit coordination
2012	Medicare Accountable Care Organizations	Career opportunities
	Medicare Independence at Home	Coverage eligibility, Benefit coordination
	Medicare Payment for Hospital Readmissions	Department reorganization, Job description
2013	Medicare Drug Coverage Gap	Coverage eligibility, Benefit coordination
	CO-OP Health Insurance Plans (Consumer Operated and Oriented Plan are nonprofit, member-run health insurance companies)	Career opportunities, Coverage eligibility, Benefit coordination
	Children's Health Insurance Program Extension	Coverage eligibility, Benefit coordination
	Disproportionate Share Hospital payment reductions	Department budget

committee's first report, *To Err Is Human: Building a Safer Heath System*, released in 1999 set the stage for addressing systemic shortcomings in the subsequent report *Crossing the Quality Chasm: A New Health System for the 21st Century* released in 2001 (IOM, 2001). This report focused on the quality aims which the health care industry should strive to achieve (see Table 2).

When one considers each of the standards for professional case management practice listed in Figure 1, it is evident that both individually and collectively support behaviors contribute to the achievement of the IOM's elements.

While not the only health care profession represented within case management, nursing is the largest by proportion, and with more than 3 million members, the profession represents the largest segment of the U.S. health care workforce (U.S. Census Bureau, 2009; U.S. Department of Health and Human Services, Health Resources and Services Administration, 2010). In the *Future of Nursing: Leading Change, Advancing Health* report, the IOM (2010) details recommendations for the advancement of nursing in the provision of quality health care.

> Nurses have also begun developing new competencies for the future to help bridge the gap between coverage and access, to coordinate increasingly complex care for a wide range of patient, to fulfill their potential as primary care providers to the full extent of their education and training, to implement systemwide changes that take into account the growing body of evidence linking nursing practice to fundamental improvements in the safety and quality of care, and to capture the full economic value of their contributions across practice settings.

The Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing formulated four key messages that structured the discussion and recommendations presented in the report:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education

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TABLE 2
Aims for the 21st-Century Health Care System

Aim	Description
Safe	Avoiding injuries to patients from the care that is intended to help them.
Effective	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
Patient-centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
Timely	Reducing waits and sometimes harmful delays for both those who receive and those who give care.
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy.
Equitable	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

system that promotes seamless academic progression.

3. Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure. (IOM, 2010, p. S-3).

This report identified major challenges facing the U.S. health care system, specifically identifying the significant amount of fragmentation present, especially at junctions of care transition. It is accepted that well-coordinated health care improves the patient care experience and enriches the quality of care. Chapter 4 of the report highlights the importance of care coordination by addressing the need to improve nursing education to be inclusive of care management and to "provide a better understanding of and experience in care management, quality improvement methods, systems-level change management, and the reconceptualized roles of nurses in a reformed health care system" (IOM, 2010, p. 4-1). These themes have been echoed throughout PPACA in care coordination and case management program provisions as well as in Medicare Payment Advisory Committee reports to Congress for the past several years.

The Shifting Health Care Horizon

On the legislative and regulatory front, the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and the PPACA of

FIGURE 1
The Case Management Society of America's 2010 Standards of Practice.

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2010 took steps in setting the stage for systemwide improvements of infrastructure and health care quality. HITECH was part of the American Recovery and Reinvestment Act of 2009, which was an economic countermeasure to the late-2000 recession. It allocated billions of dollars to the expansion and adoption of information technology to create a national network of electronic health records.

Subsequently, the PPACA brought forward the most extensive changes to the U.S. health care system since the creation of the Medicare and Medicaid programs in 1965. Ultimately, PPACA is expected to provide health coverage for an additional 32 million uninsured Americans. PPACA provisions repeatedly punctuate the focus on coordination of care and care transition initiatives as integral to demonstration projects for community-based care transitions as well as quality outcomes reporting.

As is the case in a free market system, the various entities (e.g., payer, provider, institution) are left to write their roles within the boundaries of subsequent regulation. Delivery system initiatives have been undertaken to improve quality of care focused on its specific priorities. Individual providers seek ways to modernize their respective practices with an eye on patient-inclusive strategies, popularly referred to as patient-centered care. Payers look for greatest impact on the health and wellness of its covered lives. Programs are activated that show promise of making significant positive impact but do not require the consumption of limited resources (e.g., human) or capital (e.g., infrastructure). These are what are referred to as "low-hanging fruit" and frequently counted on to produce better results than are subsequently delivered.

A degree of flexibility to innovate solutions for care delivery and support program inefficiency is essential in a market-driven system; however, it creates a great variation as to the expectations placed on case management interventions across the health care system. Known variables such as licensure-related scope of practice, certification and accreditation requirements, regulatory restrictions, organizational policy, and individual job descriptions are major influencers on practice as well. These factors beg for a consistent framework that captures the essential characteristics and competencies which should be expected of a seasoned case manager, regardless of setting or scope of practice.

A newer phenomenon of brand-naming case management programs and job titles also appears to be exerting an influence on professional cohesion. Branding is undertaken by an organization to differentiate and market their product or program as unique in highly competitive markets. Whether referred to as a coordinator, advocate, coach, navigator, or other catchy title, the effect appears to be lessening the identity, professionalism, and, in some cases, the qualifications required to perform case management functions.

One example of nonprofessional infiltration is the use of the job title *care coordinator*. Historically, this job title was one used by organizations in place of case manager. The website Education Portal (2012) provides the following introduction to what their definition of a care coordinator is:

> Care coordinators, also known as health unit coordinators, ward clerks, unit clerks and unit secretaries, work in hospitals, clinics, nursing homes, HMOs and other health care facilities. A care coordinator works under the supervision of registered nurses and health information administrators, performing non-medical tasks crucial to patient care. Care coordinators usually hold a certificate or associate's degree from a 2-year college or vocational technical school.

In this context, the job appears to be an amalgam of administrative roles performed by nonclinical staff and raises the issue of market (and consumer) expectation as well as that of title control/protection, which is discussed in more detail later in this article.

> The use of non-clinical staff, as well as licensed individuals without appropriate education or training, to perform case management activities has already begun taking place…. The impact that this approach to staffing has on quality of care or value for service delivered has yet to be clearly and consistently demonstrated. The minimum expectation should be close supervision of the individuals performing care coordination activities by a qualified nurse case manager who is a member of the collaborative patient care team. (Treiger, 2011, p. 46)

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The fracturing of case management practice into its individual components also risks the very value of the case manager being the fulcrum of coordination and collaboration of the patient care team. More research is needed to identify and quantify the impact that brand naming actually has on case management.

As new job titles have risen in popularity, so too have quasi-professional associations intended to support the individuals working under those job titles. This has resulted in a division of case management as a unified entity as these smaller organizations compete for increasingly limited membership dollars and divide membership numbers across multiple associations rather than combine our strength in a more significant total membership that expresses a more powerful locus of influence. This is already creating confusion for regulatory and legislative liaisons as those who are attempting to work with case management organizations have expressed dismay and a growing belief that an organized effort with cohesive messaging from within case management does not exist.

In addition, a by-product of this division has been that each of the professional associations, accreditation/certification entities, and for-profit corporations has taken the tasks of education and career advancement in various directions. While competition can result in a better quality and wider variety of product offerings, it should always be undertaken in the spirit of raising the bar for the entire practice, rather than to create market confusion for the case management consumer.

The Call for Outcomes-Driven Practice

For more than 20 years, the Dartmouth Atlas of Health Care project has documented disparities in the utilization and distribution of health care resources throughout United States, using Medicare data. Outcomes research has shed a harsh light on the variances of health care delivery and results produced. However, the upside of national outcomes is to spur improvements in process and care quality.

Although the function of case management has existed for decades, substantial early tracking efforts are not widely published or easily accessible. The rationale as to why historical data are not readily available today may be associated with the proprietary nature of organization-based case management programs, the ever-changing and inconsistent scope of job functions aligned under the case manager job title, the disconnect between academic institutions and workplace settings of case management practice, the failure of case management staff to approach organizational initiatives as formal process and practice improvement study opportunities, and the general lack of enthusiasm to professionalize case management practice. However, it is (or should be) crystal clear that the battle cry of evidence-based, quality improvement in today's health care industry is *outcomes, outcomes, outcomes*.

One new initiative that is focused on outcomes is the Patient-Centered Outcomes Research Institute, which was authorized by Congress to support research and to publically report best evidence in order to facilitate informed health care decision-making by patients and providers. As noted on their website, "research is intended to give patients a better understanding of the prevention, treatment and care options available, and the science that supports those options" (Patient-Centered Outcomes Research Institute, n.d.). Research priorities include comparative effectiveness of options for prevention, diagnosis, and treatment of specific health problems, health care system improvements, education of patients and other stakeholders, addressing population health and outcomes disparities, and putting forth research design that is inclusive of patient-centeredness. If case management is to fulfill its promise as a professional entity, the focus on outcomes-oriented, evidence-based intervention mandates that we collectively approach and support our practice with formal research methodologies and consistently share our findings through rigorous study and publication.

Leading efforts in this direction are the Case Management Practice Improvement and Research Awards and the creation of the Case Management Foundation. The two awards, Practice Improvement and Research, recognize the "individual, group, or organization that uses finding from a research or quality/performance improvement (QI/PI) project for innovation in the advancement of case management practice and/or improved client outcomes" (CMSA, 2012a). The Case Management Foundation's (2012a) mission is "to support education, research, and professional development for case management professionals." Additional support of efforts to enhance research and process improvement initiatives is necessary to consistently document the contribution that case management makes across every sector of the health care industry.

Medical Loss Ratio

The medical loss ratio is the percentage of health insurance premium dollars spent on clinical services and activities to improve health care quality. The PPACA and subsequent regulation require health insurers to report their medical loss ratio through an extensive calculation process. When the percentage does not meet minimum standards of at least

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80% or 85% (depending on the type of plan), the insurance company is required to issue a rebate to their members. This became effective in August 2012.

Reporting by group health plans and issuers of health insurance regarding quality programs that were defined as those that:

- improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the PPACA, for treatment or services under the plan or coverage;
- implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and postdischarge reinforcement by an appropriate health care professional;
- implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; and
- implement wellness and health promotion activities. (Patient Protection and Affordable Care Act consolidated, 2010)

There are also activities, previously included within the scope of case management programs, that are no longer included within the definition of clinical service or quality improvement, such as concurrent and retrospective utilization review, collection of clinical data without subsequent data analysis, and 24-hour health care professional hotline that handles nonclinical member inquiries. The relevance to case management in the payer sector is the likelihood of ongoing shifts in the responsibility for utilization review activity, as well as job title changes.

Case Management's Identity Disorder

"Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes" (CMSA, 2010, p. 6). This 1995 definition adeptly captured the essence of many case management roles during the formative years of this advanced practice. The energy of this action-oriented merging of verbs aligned with the aforementioned CMSA Standards of Practice was strong enough to secure case management's position in the rapidly changing health care industry, one with an evolving managed care presence.

Consider the grand challenge for consumers, plus vested industry stakeholders in working to comprehend the similarities and distinctions between so many framings for case management. For example, case manager, care manager, geriatric care manager, care coordinator, caseworker, care advocate, patient advocate, patient navigator, health care coach, and others. This role multiplicity and fragmentation are yet one more obstacle impacting case management's maturity from advanced practice to profession.

Now, 18 years hence, the industry has exploded with an onslaught of case management associated titles, roles, functions, and job descriptions for a range of business models spanning practice settings across transitions of care. Some might challenge that this expansion has contributed to a paradoxical effect on case management's identity as a profession.

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The last 20 years have witnessed strong efforts to ground and formalize case management, including the development of model acts to establish templates for professional practice through legislation. Others were cited earlier in this article. The Case Management Model Act proposed standards for case management services with key provisions for staff qualifications, case management functions, scope and payment of services, training requirements, quality management programs, and antifraud and consumer protections. The Act could serve as a template for legislation at the federal, local, or regulatory level (CMSA, 2009).

On a similar vein, Title Protection has also been broached as a means to professionalize case management (Powell, 2011). This legislation has

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been occurring within social work across the globe over the past several decades. This action is motivated by assorted factors from consumer protection to recognition of social work as a specialized profession and not just a job title. Although the efforts and language of the laws in each jurisdiction vary, the theme is similar; one is unable to call himself or herself a social worker without the requisite BSW and/or MSW degree from a Council on Social Work Education (2012)–accredited social work program, plus potentially the minimal level of licensure for that jurisdiction. In the year 2000, the United Kingdom passed Title Protection under its *Care Standards Act* of that year. Per section Chapter 14 (Part 1V) Section 61, "no one can describe herself or himself as a social worker unless he or she is registered in the Social Care Registry maintained by the General Social Care Council" (Murray & Hendricks, 2011). The National Association of Social Workers and its individual chapters have worked diligently to move Title Protection forward. In this consumer-focused health care environment, the question beckons: Should consumers receiving intervention from social workers (or case managers) not be assured that it is rendered by competent, licensed professionals who have received appropriate education and training?

Further diffusion of case management is evidenced through the number of emerging case management professional associations, each with unique practice standards that are aligned though still distinct. Several associations have developed their own specialty credential(s). At the time of this writing, there are, in fact, 21 certifications and six separate organizational accreditations for case management identified (CMSA, 2012a).

Higher education has seen the growth of a wide range of case management educational programs. The question of which discipline owns case management may impact where these programs may reside. While some curricula appear under the auspices of social work and psychology departments, a majority are found in nursing departments and schools. They span comprehensive certificate programs, like those at Rutgers School of Social Work (2012) and the University of Pittsburgh School of Social Work (2012) to more traditional graduate coursework with the rendering of a master's degree. Of particular note is the University of Alabama's Capstone College of Nursing, which offers an MSN in case management. This program prepares nurses to assume leadership positions in health care administration, plus coordinate and administer case management services at the macrosystems level (University of Alabama, Capstone College of Nursing, 2012).

With the newest edition of the *Diagnostic and Statistical Manual for Psychiatric Disorders* (*DSM 5*) being released this month, one might, at this point in the article, be inclined to look for a new diagnosis: CMID Case Management Identity Disorder. As tempting, and for that matter humorous, as it may be to coin a new diagnosis, it may be more appropriate to relate case management's identity disorder in a similar context as Health Information Technology's (HIT's) sudden and expansive growth. "Health technology innovation is captivating providers, practitioners, patients, and product developers alike" (Fink-Samnick, 2012a, p. 10). The revenue is staggering, as remote monitoring of patients is anticipated to grow into a $6 billion market by 2016 (Dolan, 2012). However, despite HIT's massive popularity and promise, some argue that too much is occurring too quickly. Similar to case management, everyone wants in, but not all are ready to engage optimally. Practice inconsistencies have manifested for HIT, much like they have for case management. Obstacles warrant clarification and attention such as those regulatory barriers imposed to licensure portability by lack of an optimal state-to-state licensure system for this market (Fink-Samnick, 2012b).

The editorial for issue 18(1) of this journal (Powell & Fink-Samnick, 2013, p. 2) posed three key questions for case management's individual and collective consideration:

1. What does this latest technology trend mean for the majority of today's case managers, who are now older than 50 years (CMSA, 2012b)?
2. With retirement nearer than farther, how will the workforce keep up in terms of knowledge acquisition, scope of practice, and definition of new competencies?
3. Will demand for competent case managers exceed supply?

Add to these questions, the need for case management to claim a firm professional stake in the ground and the $64M question beckons: *How is a COMPETENT Case Manager defined?* Some might suggest that the answer(s) exists among those entities that share monitoring responsibility and/or accountability for educational, professional, organizational, and institutional oversight.

The Competencies Path

In 1995, the Joint Commission on Hospital Accreditation required hospitals to assess, prove, track, and improve the *competence* of all employees. *Competency* was defined as the determination of an individual's capacity to perform up to defined expectations (The Joint Commission on Accreditation of Healthcare Organizations, 2000). The practice bar was raised with a new course set on health care's

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horizon, one toward competency-based practice. The steady stream of new competency programs across the industry was viewed as, not only mandated for The Joint Commission adherence, but also served:

1. To help facility leaders stay focused on their primary objective: the facility's mission statement.
2. To assist in matching applicants to open positions.
3. To ensure ongoing assessment of staff competency from system entry through the remainder of the person's association with the organization (Summers & Woods, 2008, p. 4).

During this time, it was not uncommon for organizations to develop job descriptions with focused competencies versus the more traditional format of roles and/or functions. This also contributed to supporting organizational expectations for high-quality services (Summers & Woods, 2008).

In 2003, the IOM put forth a pivotal recommendation: to convene accreditation, licensing, and credentialing organizations across the spectrum of all health care professions. The goal of this effort was to transition the mindset of these respected entities by moving them to competency-based oversight, which would include five core competencies (IOM, 2003):

1. Provide patient-centered care.
2. Work in interdisciplinary teams.
3. Employ evidence-based practice.
4. Apply quality improvement.
5. Utilize informatics.

The urgency to ground core competencies was equally being acknowledged by academia, as the gateway for budding professionals. Accreditation organizations were already tasked with the rigorous job of developing standards to define a student's competent preparation for each distinct practice discipline, so it stands to reason they should be involved in identifying accompanying professional competencies. For social workers, this is managed through the Council on Social Work Education (2012) and for nursing through the American Association of Colleges of Nursing (2012). Examples of the competencies developed by each organization appear later (see Table 3).

Moving along the professional practice achievement continuum, competencies set the foundation for two more integral processes. First, through the development of licensure examinations, for social workers and nurses this includes the work of the Association of Social Work Boards (2012) and The National Council of State Boards of Nursing (2012). Each of these entities engages in a rigorous process to define, operationalize, and, as necessary, revise the competencies for per licensure level. The Association of Social Work Boards has four examination levels: bachelors, masters, advanced generalist, and clinical. Each examination has a unique set of competencies to reflect the knowledge, skills, and abilities expected to be mastered. The National Council of State Boards of Nursing (2012) offers two examinations, registered nurse and practical/vocational nurse, each having unique content, as well.

The second area involves individual state boards, which includes among their responsibilities to define an individual's eligibility for licensure in that jurisdiction. Involved in this process is often a review of the candidate's ability to meet a series of competencies developed by the requisite professional board.

TABLE 3
AACN and CSWE Competencies

AACN Competencies (AACN, 2012)	CSWE Core Competencies (CSWE, 2012)
1. Quality improvement	1. Identify as a professional social worker and conduct oneself accordingly
2. Safety	2. Apply critical thinking to inform and communicate professional judgments
3. Teamwork and collaboration	3. Advance human rights and social and economic justice
4. Patient-centered care	4. Apply knowledge of human behavior and the social environment
5. Evidenced-based practice	5. Engage in research-informed practice and practice-informed research
6. Informatics	6. Apply social work ethical principles
	7. Engage diversity and difference in practice
	8. Engage in policy practice to advance social and economic well-being
	9. Respond to contexts that shape practice
	10. Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities

Note. AACN = American Association of Colleges of Nursing; CSWE = Council of Social Work Education.

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The IPEC document not only leveraged the work of the IOM and academic accreditation entities but also reinforced a powerful message. Health care quality is a comprehensive and consolidated team effort, which is interprofessional, and thus transdisciplinary in scope.

Competencies Transcend Professional Disciplines

Leveraging the IOM recommendations, six entities formed the Interprofessional Education Collaborative (IPEC, 2011):

- American Association of Colleges of Nursing
- American Association of Colleges of Osteopathic Medicine
- American Association of Colleges of Pharmacy
- American Dental Education Association
- Association ofAmerican Medical Colleges
- Association ofSchools of Public Health

The goal of this interprofessional effort was to prepare health care professions students for *deliberatively working together*, with the common aim of building a safer and better patient-centered and community/population-oriented U.S. health care system. In 2011, the IPEC published Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel (IPEC, 2011). Eight reasons were cited to create this approach:

1. Create a coordinated effort across the health care professions to embed essential content in all health care professions education curricula.
2. Guide professional and institutional curricular development of learning approaches and assessment strategies to achieve productive outcomes.
3. Provide the foundation for a learning continuum in interprofessional competency development across the professions and the lifelong learning trajectory.
4. Acknowledge that evaluation and research work will strengthen the scholarship in this area.
5. Prompt dialogue to evaluate the "fit" between educationally identified core competencies for interprofessional collaborative practice and practice needs/demands.
6. Find opportunities to integrate essential interprofessional education content consistent with current accreditation expectations for each health care professions education program.
7. Offer information to accreditors of educational programs across the health care professions that they can use to set common accreditation standards for interprofessional education, and to know where to look in institutional settings for examples of implementation of those.
8. Inform professional licensing and credentialing bodies in defining potential testing content for interprofessional collaborative practice.

The IPEC goes on to define four critical primary competency domains identified, each including a specific list of associated values and specific competencies:

- Competency Domain 1: Values/Ethics for Interprofessional Practice
- Competency Domain 2: Roles/Responsibilities
- Competency Domain 3: Interprofessional Communication
- Competency Domain 4: Teams and Teamwork

The IPEC document not only leveraged the work of the IOM and academic accreditation entities but also reinforced a powerful message. Health care quality is a comprehensive and consolidated team effort, which is interprofessional and thus transdisciplinary in scope. With the integral role competencies serving to ground accreditation, institutional and organizatvional approaches, it is not surprising that their popularity in defining and framing a profession's perspective would be equally valuable.

COLLABORATE©: A Universal Competency-Based Paradigm for Professional Case Management Practice

COLLABORATE© was born of a vision: the mandate to solidify a firm foundation for case management composed of unique action-oriented competencies, which transcends professional disciplines, practice settings, and educational levels. This focus promotes effective transdisciplinary collaboration.

COLLABORATE© recognizes the hierarchy of competencies and practice behaviors defined by the educational levels of all professionals engaged; associate, bachelor's, master's, and doctoral degrees. Through this approach, every qualified health and human service professional has a valued place setting at case management's ever-expanding table.

Each of the 11 competencies presented is mutually exclusive and uniquely defined, as noted in Table 4. While appearing in order for the acronym's sake, they are not necessarily sequential. However, when united in a comprehensive and strategic effort, the COLLABORATE© competencies drive a purposeful, powerful case management paradigm.

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TABLE 4
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:
		• Academia & advanced degrees
		• Professional development
		• Evolution of knowledge requirements for new and emerging trends (e.g., technology, innovation, reimbursement)
		• Practicing at the top of licensure and/or certification
		Acknowledging no one case manager can and does know all
L	Leadership	Professional identity
		Self-awareness
		Professional communication-verbal/nonverbal,
		Team coordinator: a unifier rather than a divider
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
		• Professional disciplines
		• Across teams
		• Across the continuum
E	Ethical-Legal	Licensure
		Certification
		Administrative standards
		Organizational policies and procedures
		Ethical codes of conduct

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The agility of the paradigm extends to the use of key concepts that include both actionoriented verbs and nouns, which are significant elements in any professional case management endeavor.

This article's intent is to introduce each competency with its specific elements. We recognize the need to further detail how to both operationalize and implement each competency; the primary focus for the next article in this series.

Conclusion: In Moving Forward

In moving forward, the one fact that rings true is that there will be 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 why the definition of a competency-based case management model's time has come, one sufficiently fluid to fit into any setting of care.

The second article of this series will provide clarification and detail of the COLLABORATE© competency-based paradigm with a graphic depiction. Operationalizing the model, including approaches to return on investment, will be addressed in Part 3. We invite you to join us on this dynamic and innovative journey.

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