

# CCM Certification

# MADE EASY

**4th Edition**

**Companion Workbook**

**Deanna Cooper Gillingham, RN, CCM, FCM**

# CCM Certification Made Easy

## Companion Workbook

4th Edition

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ISBN Paperback: 978-1-943889-20-4

Library of Congress Control Number: 2025909929

First paperback edition December 2014, 2nd Ed. July 2016, Revised 2nd Ed. July 2019, 3rd Edition August 8, 2020

Edited by Andrea Morris, [aripemango.com](http://aripemango.com)

Blue Bayou Press, LLC

5753 Highway 85N #4010

Crestview, FL 32536

[BlueBayouPress.com](http://BlueBayouPress.com)

[CaseManagementInstitute.com](http://CaseManagementInstitute.com)

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# Chapter One: Getting Started

**Eligibility Self-check**

I meet the eligibility criteria because:

**1. License/Certification or Education (Only a or b)**

a.  I have a license or certification that meets the criteria

License/Certification type (RN, PT,etc.) \_\_\_\_\_

License/Certification expiration date \_\_\_\_\_

The license/certification will be valid through the testing month (Y/N) \_\_\_\_\_

b.  I have a degree that meets the eligibility requirements

**2. Employment Experience (only 1 is needed)**

I have:

12 months of acceptable full-time case management employment experience supervised by a CCM who has been certified for at least 12 months.

24 months of acceptable full-time case management employment experience.

12 months of acceptable full-time case management employment experience as a supervisor of individuals who provide case management services.

Supervisor's name: \_\_\_\_\_

Supervisor's contact email: \_\_\_\_\_

**3.  I meet the moral character requirement.**

## Chapter 2: Care Management

Most case management models are a variation of one of the following:

\_\_\_\_\_ – In this model, a single nurse case manager performs all three responsibilities. A social worker may be consulted when appropriate.

\_\_\_\_\_ – Here, registered nurse (RN) and social worker (SW) CMs work together in the case management department. They may co-manage the patient, with the RN handling education and medical issues and the SW focusing on financial, social, and discharge needs. Alternatively, an initial assessment may determine whether the client's primary needs are medical or social; the appropriate CM would take responsibility for the client, with the other available as a resource.

\_\_\_\_\_ – This model is like the dyad model, but a third person takes on utilization manager (UM) activities (working with payers), leaving the RN and SW CMs to focus on patient flow, transitions, and DCP.

\_\_\_\_\_ – (not to be confused with integrated *inpatient* case management) was developed to better serve clients with both physical and mental conditions. In this model, a single CM assists the client and his support system on all barriers to health, including those related to mental health and substance use disorders.

\_\_\_\_\_ – the CM provides case management services virtually via telephone, email, or videoconferencing.

\_\_\_\_\_ – used by insurance companies/payers, workers' compensation, and community-based organizations, with the CM visiting the client at home or in the community. For workers' compensation specifically, a single CM communicates with the worker, the employer, and the physician. The CM attends medical appointments with the injured worker and may visit the client's home and work site. The CM is responsible for medical case management, return-to-work coordination, and job site analysis.

## The case management process

According to the Commission for Case Manager Certification (CCMC), the case management process consists of the following phases:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Phases take place \_\_\_\_\_, or they're revisited and repeated as needed.

To determine if a potential client may be appropriate for case management, the first step in the case management process is for the case manager to review the individual's health situation, including (but not limited to) his \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ status.

During screening, a CM may review whether the patient has experienced:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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After a client has been regarded as appropriate for case management services, a \_\_\_\_\_, \_\_\_\_\_ assessment is conducted.

The CM should interview the \_\_\_\_\_ whenever possible.

Health aspects considered vary based on the case manager's practice setting. They may include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
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The next phase is risk stratification, a process that uses \_\_\_\_\_ and \_\_\_\_\_ tools to aid in classifying clients as low, moderate, or high risk.

During the \_\_\_\_\_ phase, the CM \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ long-term and short-term objectives based on the previous assessment. Effective objectives are “\_\_\_\_\_”: **S**\_\_\_\_\_, **M**\_\_\_\_\_, **A**\_\_\_\_\_, **R**\_\_\_\_\_, and **T**\_\_\_\_\_.

The plan also describes the accompanying \_\_\_\_\_—the treatments, resources, and services used to meet the objectives.

Planning is \_\_\_\_\_ whenever possible, with input from the client, caregiver, and members of the healthcare team. The result of the planning phase is an individualized \_\_\_\_\_.

The \_\_\_\_\_ phase, also called 'care coordination,' occurs as the Case Management Plan of Care is carried out.

During the \_\_\_\_\_ phase, the CM monitors the client's response to interventions and evaluates progress toward desired outcomes to gauge the appropriateness of the plan.

In the \_\_\_\_\_ phase of the case management process, the CM assesses the client and his support system's readiness to transfer to another level of care, facility, or provider, or to discharge to home.

After the transition, the case \_\_\_\_\_ to confirm a \_\_\_\_\_ and determine how the ongoing treatment is progressing. The case manager \_\_\_\_\_ medications, ensures \_\_\_\_\_ are obtained, and assesses for issues.

### Evaluating outcomes

In the final phase of the case management process, the CM \_\_\_\_\_ by measuring the results, consequences, and outcomes of the services provided to the client and his support system.

The evaluation may examine multiple aspects of care, including:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

According to CCMC, assessment is "the \_\_\_\_\_ of collecting in-depth information about a person's \_\_\_\_\_ and \_\_\_\_\_ to identify \_\_\_\_\_ needs in order to develop a \_\_\_\_\_ that will address those needs."

A \_\_\_\_\_ assessment looks at a client's health and functional status, including:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

ADLs measure the level of independence on performing six basic activities:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

IADLs include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Tools to screen for depression

The \_\_\_\_\_ pre-screens for depression. Clients who pre-screen positive are further evaluated using the \_\_\_\_\_.

### Tools to screen for health-related social needs

The \_\_\_\_\_ is a 10-item questionnaire developed by the Center for Medicare & Medicaid Services (CMS). The AHC HRSN Screening Tool focuses on five core domains:

- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The assessment process must \_\_\_\_\_ and consider each client's unique \_\_\_\_\_ background and \_\_\_\_\_ needs.

A client-centered plan of care starts with understanding that clients are the experts on their own lives and needs, so CMs must include the \_\_\_\_\_ and \_\_\_\_\_ input when developing a plan of care.

Developing a client-centered care plan includes three essential, interconnected steps:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_ are the treatments, resources, and services used to meet the client's needs and goals.

The \_\_\_\_\_ is comprised of healthcare professionals and paraprofessionals from various disciplines involved in a client's care.

Many \_\_\_\_\_ needs, such as home modifications, caregivers, healthy meals, and transportation to medical appointments, are not covered by insurance. The CM arranges \_\_\_\_\_ to address these needs.

Coordination is "the process of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ the resources necessary to accomplish the goals set forth in the case management plan" (CCMC Glossary of Terms, 2022).

Throughout the continuum, the CM promotes the patient's \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_. She \_\_\_\_\_ for the client to secure the right \_\_\_\_\_ in the right \_\_\_\_\_ at the right \_\_\_\_\_.

\_\_\_\_\_ occur when a client moves between care settings, providers, or levels of care. They occur:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

CM responsibilities related to transitions of care include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

To ensure safe transitions and proper communication between providers, the Centers for Medicare & Medicaid Services (CMS) requires a \_\_\_\_\_ for each transition.

During the post-transition communication phase, the case manager contacts the \_\_\_\_\_, inquires about his condition, and determines how ongoing treatment is progressing. During this follow-up, the case manager verifies that \_\_\_\_\_.

Case managers' three primary medication responsibilities are \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

Medication reconciliation is "the process of examining and monitoring all medications taken by a client to determine their \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ in order to reduce the number of adverse drug effects and promote client's adherence to the medication regimen" (CCMC, 2022).

When should medication reconciliation occur?

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

During medication reconciliation, case managers review the following:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Common medication access barriers include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Medication nonadherence takes many forms. \_\_\_\_\_ occurs when a patient does not fill a prescription, and \_\_\_\_\_ occurs when patients do not take a medication as prescribed.

Education also increases adherence. The case manager may fill knowledge gaps related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Clients who understand the purpose and importance of their medication(s) are more likely to adhere to them. The case manager's regular follow-up helps reinforce education and allows for the early identification and resolution of any new barriers to adherence that may arise.

Circumstances that affect caseload size include:

Operational factors

- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Professional factors

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Population factors

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Other factors should be considered when possible:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

When managing a client with acute illness, the case manager \_\_\_\_\_, such as \_\_\_\_\_ or \_\_\_\_\_. If the patient is unable to discharge directly home, the case manager \_\_\_\_\_ to inpatient rehabilitation, a long-term acute care hospital, or other suitable facility.

CMs teach patients with \_\_\_\_\_ to manage their conditions to \_\_\_\_\_ and \_\_\_\_\_.

CCMC defines disability case management as a process of managing occupational and nonoccupational diseases with the aim of \_\_\_\_\_ (CCMC Glossary of Terms, 2022).

After an injury or illness has occurred, the CM's immediate focus is to \_\_\_\_\_.

Client \_\_\_\_\_ through education is crucial in behavioral health case management.

To help clients explore and strengthen their motivation for change, CMs use \_\_\_\_\_. Rather than telling clients what to do, case managers use \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ to guide clients as they identify their reasons for change.

Many behavioral health clients receive their care in community behavioral healthcare settings, and some resist accessing primary care. To solve this concern, \_\_\_\_\_ programs bring primary care services, prevention services, and wellness activities directly to behavioral health settings.

According to CCMC, the \_\_\_\_\_ is "the intensity and effort of health and human services and care activities required to \_\_\_\_\_, \_\_\_\_\_ or \_\_\_\_\_ a client's health" (CCMC Glossary of Terms, 2022).

During \_\_\_\_\_ the patient is formally admitted to the hospital under a physician's order. The client requires care that can only be provided in the \_\_\_\_\_, with daily \_\_\_\_\_ and nursing care. The decision to admit must meet \_\_\_\_\_ based on the \_\_\_\_\_ and the \_\_\_\_\_ of service required.

\_\_\_\_\_ is a unique designation, in which the client requires short-term monitoring and evaluation to determine if inpatient admission is warranted.

\_\_\_\_\_ consists of services that don't require inpatient hospital admission.

\_\_\_\_\_ care provides intermittent skilled care to patients in their homes.

\_\_\_\_\_ provides end-of-life care to patients with terminal illnesses and supports their families.

\_\_\_\_\_ care assists with personal and home care such as ADLs and IADLs. This level of care does not require a skilled or licensed provider.

According to CCMC, a \_\_\_\_\_ is "a place across the continuum of health and human services where a client may receive healthcare services dependent on need" (CCMC Glossary of Terms, 2022).

\_\_\_\_\_ care is the most intensive level of care, during which a patient is treated for a brief but severe episode of illness, for conditions that result from disease or trauma, or during recovery from surgery. \_\_\_\_\_ is generally provided in a \_\_\_\_\_ or a \_\_\_\_\_, also known as long-term care hospitals (LTCH), by a physician and a variety of clinical personnel.

\_\_\_\_\_ are for patients who are stable and do not require hospital acute care but who require more intensive skilled nursing care, therapy, and physician services than are provided in a skilled nursing facility.

\_\_\_\_\_ provide intense, multidisciplinary therapy to patients with functional loss. To qualify for this level of care, patients must be \_\_\_\_\_ and able to tolerate a minimum of three hours of therapy daily, five to seven days a week.

\_\_\_\_\_ offer 24-hour skilled nursing and personal care (e.g., bathing, eating, and toileting). They also provide rehabilitation services, such as physical, occupational, and speech therapies. Patients must be \_\_\_\_\_ to qualify for \_\_\_\_\_ care. They must also require daily care from a \_\_\_\_\_.

\_\_\_\_\_ provide residents housing and support for ADLs and IADLs.

\_\_\_\_\_ typically house children or adults with chronic disabilities who require continual assistance to complete ADLs/IADLs or who experience behavioral problems that make them dangerous to themselves or others.

\_\_\_\_\_ house and provide therapy for patients with drug and alcohol addictions, emotional or behavioral problems, and/or mental illness. They are \_\_\_\_\_ focused and offer treatments such as psychoanalytic therapy, behavioral management, group counseling, family therapy, and medication management.

\_\_\_\_\_ provides comprehensive end-of-life care and support, including palliative care, to terminally ill patients and their families.

A Do Not Resuscitate (DNR) order (is/is not) required to enroll in hospice.

Multiple tools are used to assess hospice appropriateness, including:

\_\_\_\_\_ – This scale measures performance status on a scale from 0 to 100 percent, with 0 being deceased and 100 being normal with no complications. A score of less than 70 percent (cares for self but is unable to carry on normal activities or work) can be one of the criteria for hospice.

\_\_\_\_\_ – A 0-4 scale, with 0 being fully active and 4 being completely disabled.

\_\_\_\_\_ – This tool scores on five observer-rated domains (ambulation, activity level/evidence of disease, self-care, intake, and level of consciousness), correlated to the Karnofsky Performance Scale. It is often used in determining hospice appropriateness for cancer patients.

\_\_\_\_\_ can be provided at any stage of a severe illness, and it can be used concurrently with curative treatment; it is not dependent on a terminal prognosis.

\_\_\_\_\_ is specialized medical care for patients suffering from severe and chronic illnesses, such as cancer, CHF, COPD, kidney failure, or ALS. The goal is for the patient and his family to \_\_\_\_\_

\_\_\_\_\_ can improve a patient's ability to tolerate medical treatments, such as chemotherapy and radiation.

Chronic pain management typically involves both:

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ must be drawn up while the client is \_\_\_\_\_ and are only used if the client is \_\_\_\_\_ or \_\_\_\_\_ to speak for himself.

Advance directives come in two forms:

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_, this type of advanced directive stipulates who will make healthcare decisions for the client if he is unable to do so himself.

A \_\_\_\_\_ is a legal document that states which specific life-sustaining medical treatments a person wishes to receive or have withheld if he or she becomes terminally ill or in a permanent vegetative state.

\_\_\_\_\_ and \_\_\_\_\_ are types of advance directives that indicate the person does not want CPR attempted.

\_\_\_\_\_: ages 1 day to 28 days

Psychosocial developmental task – \_\_\_\_\_: the ability to \_\_\_\_\_

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : ages 29 days to 1 year

Psychosocial developmental task – \_\_\_\_\_ : the ability to

\_\_\_\_\_  
Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : ages 1 year to 3 years

Psychosocial developmental task – \_\_\_\_\_ : sense of \_\_\_\_\_, sense of \_\_\_\_\_

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : ages 3 years to 12 years

\_\_\_\_\_ : ages 3 years to 5 years

Psychosocial developmental task – \_\_\_\_\_ : exploring and seeking answers, feeling \_\_\_\_\_ for making a mistake or disappointing parents

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : ages 6 years to 12 years

Psychosocial developmental task – \_\_\_\_\_ : making things, solving problems, and mastering tasks to \_\_\_\_\_ and \_\_\_\_\_

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : ages 13 years to 18 years

Subcategories: \_\_\_\_\_ (13-15 years) and \_\_\_\_\_ (16-18 years)

Psychosocial developmental task – \_\_\_\_\_ versus \_\_\_\_\_ : searching for a \_\_\_\_\_ and \_\_\_\_\_ through intense \_\_\_\_\_ of personal values, beliefs, and goals; may include \_\_\_\_\_ and \_\_\_\_\_ and developing relationships with the opposite sex

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Other considerations during this stage:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : 19 years to 65 years

\_\_\_\_\_ : ages 20 years to 29 years

Psychosocial developmental task – \_\_\_\_\_ versus \_\_\_\_\_ : forming an intimate, loving, and committed relationship with another person

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : ages 30 years to 65 years

Psychosocial developmental task – \_\_\_\_\_ ("\_\_\_\_\_") versus \_\_\_\_\_ : contributing to the \_\_\_\_\_ and

\_\_\_\_\_, equally concerned with providing for \_\_\_\_\_ and providing for \_\_\_\_\_

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Other considerations during this stage:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ : 65 years and older

Subcategories: \_\_\_\_\_ (65-75 years), \_\_\_\_\_ (75-85 years), \_\_\_\_\_ (85 years and older)

Psychosocial developmental task – \_\_\_\_\_ versus \_\_\_\_\_ : the \_\_\_\_\_

Risk assessment and teaching related to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Other considerations during this stage:

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ aims to improve health outcomes for specific groups by addressing their unique needs. It considers various factors influencing health, including \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

Strategies for population health management include:

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Population health foundational concepts

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In the \_\_\_\_\_, collaboration and care coordination among pediatricians, schools, and specialists is important. The focus is on \_\_\_\_\_, \_\_\_\_\_, and support for \_\_\_\_\_.

\_\_\_\_\_ population health promotes women's physical, mental, and social well-being during pregnancy, childbirth, and postpartum to improve health outcomes for mothers and their infants.

\_\_\_\_\_ health aims to manage the health and well-being of the aging population within a community, promoting \_\_\_\_\_, \_\_\_\_\_, and maintaining \_\_\_\_\_. \_\_\_\_\_ are particularly important for the geriatric population, as they frequently change care settings.

Case managers inherently create \_\_\_\_\_ when performing their core activities and functions, such as managing resources or ensuring the appropriate level of care. However, the case manager's primary responsibility is to ensure the client \_\_\_\_\_ and achieves \_\_\_\_\_. Thus, CMs must balance \_\_\_\_\_.

\_\_\_\_\_ with \_\_\_\_\_ for necessary services.

Case managers ensure clients receive care at the \_\_\_\_\_ and \_\_\_\_\_ level and setting. This includes \_\_\_\_\_ to lower levels of care when appropriate.

Effective \_\_\_\_\_ prevents costly gaps, fragmentation, and duplication of services. Since clients are at high risk during \_\_\_\_\_, case managers focus on facilitating \_\_\_\_\_ and \_\_\_\_\_ to prevent costly delays and adverse events.

Case managers evaluate the \_\_\_\_\_ and \_\_\_\_\_ (e.g., determining whether medical necessity criteria are met for admission or whether a continued stay at the current level of care is justified).

By identifying \_\_\_\_\_, case managers implement interventions that prevent costly complications.

Case managers \_\_\_\_\_ for services outside standard benefits when necessary for optimal outcomes, such as additional therapy visits or specialized equipment.

## Chapter 3 Reimbursement Methods

In general, \_\_\_\_\_ services are reasonable, necessary, appropriate, and based on evidence-based standards of care. Cosmetic procedures are usually not considered medically necessary.

Cost sharing comes in the form of \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

A \_\_\_\_\_ is a set amount the patient pays each time a specific service is rendered.

The \_\_\_\_\_ and \_\_\_\_\_ work together. The \_\_\_\_\_ is a specific dollar amount the patient must pay for covered expenses before the insurance company begins paying. Once the \_\_\_\_\_ has been paid, \_\_\_\_\_ kicks in, with the insurance company and the patient sharing the remaining costs until the maximum out-of-pocket limit is reached.

\_\_\_\_\_ are the healthcare services, treatments, and supplies the insurance company agrees to cover.

\_\_\_\_\_ health insurance is offered by an employer to its employees. Employers can purchase a \_\_\_\_\_, where claims are paid by the insurance company, or they may choose to \_\_\_\_\_.

\_\_\_\_\_ (also referred to as \_\_\_\_\_) do not pay a fixed premium to an insurance carrier. Instead, they pay claims from \_\_\_\_\_ as claims are incurred.

Self-insured employers may insure against very large claims by purchasing \_\_\_\_\_, \_\_\_\_\_, or \_\_\_\_\_ insurance. They often contract with \_\_\_\_\_ or \_\_\_\_\_ companies to handle the administrative aspects of insurance, such as utilization review and processing claims.

\_\_\_\_\_ is purchased by individuals or families rather than provided by employers.

CCMC defines \_\_\_\_\_ as “benefits in the form of payments rather than services.”

\_\_\_\_\_ services reduce and control the cost of prescription medications for their members using many strategies.

They also maintain a \_\_\_\_\_—a list of drugs approved for reimbursement—which are organized into cost tiers, with generic drugs being the cheapest, followed by formulary medications.

\_\_\_\_\_ provides employees and their families (spouses, former spouses, and dependent children), who might otherwise lose their employer-sponsored health insurance due to certain events, the opportunity to continue their insurance for a limited period.

<b>Summary of COBRA qualifying events, beneficiaries, and maximum periods of continuation coverage</b>		
QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE
Termination (for reasons other than gross misconduct) or reduction in hours of employment	Employee Spouse Dependent Child	
Disability	Employee Spouse Dependent Child	
Employee enrollment in Medicare	Spouse Dependent Child	
Divorce or legal separation	Spouse Dependent Child	
Death of employee	Spouse Dependent Child	
Loss of “dependent child” status under the plan	Dependent Child	

Reprinted from “An employer’s guide to group health continuation coverage under COBRA,” by Employee Benefits Security Administration, 2018, p.11. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf>

Public benefits programs include \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, and  
\_\_\_\_\_. Individuals who are entitled to both \_\_\_\_\_  
and \_\_\_\_\_ are called \_\_\_\_\_.  
\_\_\_\_\_ always pays last.

\_\_\_\_\_ is health insurance provided by the U.S. government for  
people 65 or older, certain younger people with disabilities, and people with end-stage  
renal disease (ESRD).

Eligibility criteria for Medicare benefits:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Medicare has 4 parts:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Medicare Part A pays for:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

To qualify as an inpatient for Medicare payment purposes, the patient must pass CMS's  
\_\_\_\_\_.

In general, the \_\_\_\_\_ states that inpatient  
admissions are generally payable under Medicare Part A if the admitting practitioner  
expects the patient to \_\_\_\_\_,  
and \_\_\_\_\_.

A patient who does not meet the criteria for inpatient admission will be placed in \_\_\_\_\_, paid under \_\_\_\_\_, with numerous implications:

- A \_\_\_\_\_ usually pays 20 percent coinsurance, a copayment, and a deductible, if applicable, for services received.
- Medicare Part A covers skilled nursing facility care *only* if the beneficiary has had a medically necessary inpatient hospital stay lasting \_\_\_\_\_ for illness or injury.
- \_\_\_\_\_ does not cover prescription or over-the-counter drugs a beneficiary receives while in a hospital outpatient setting.

A Medicare patient who has been receiving observation or outpatient services for more than 24 hours must receive a “\_\_\_\_\_” (\_\_\_\_\_) document, which informs the patient they have outpatient (not inpatient) status in a hospital or critical access hospital.

#### Inpatient hospital coverage under Medicare Part A

Medicare covers up to \_\_\_\_\_ of medically necessary inpatient hospital care per benefit period.

About benefit periods:

- A benefit period begins when \_\_\_\_\_ and ends when the patient has been out of the \_\_\_\_\_ for at least \_\_\_\_\_ consecutive days.
- There is \_\_\_\_\_ limit to the number of benefit periods covered during a beneficiary’s lifetime.
- A deductible is required for days \_\_\_\_\_ of each benefit period.
- Copayment is required for days \_\_\_\_\_.
- When the \_\_\_\_\_ of inpatient hospital care during a benefit period have been exhausted, the beneficiary can use days from a non-renewable “\_\_\_\_\_” of \_\_\_\_\_ additional days of inpatient hospital care.

Medicare Part A covers semi-private rooms, meals, skilled nursing, rehabilitative services, and other medically necessary services and supplies furnished in a skilled nursing facility only if they are \_\_\_\_\_ and within \_\_\_\_\_ of an inpatient hospital stay of \_\_\_\_\_ days or more (not including the day of discharge) for a related illness or injury.

There is no copayment for the first \_\_\_\_\_ days in an SNF during a benefit period. Days \_\_\_\_\_ incur a daily copayment. The benefit period is limited to \_\_\_\_\_ days; after that, the patient is responsible for all costs.

Once the \_\_\_\_\_ has started, Medicare Part A will cover all care related to the terminal illness, as long as the care is coordinated by the hospice provider. Covered care includes:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
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- \_\_\_\_\_
- \_\_\_\_\_

**What Medicare hospice benefit does not cover**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Even after beginning the hospice benefit, Original Medicare (Parts A & B) will pay for \_\_\_\_\_.

However, the patient is responsible for the \_\_\_\_\_ Original Medicare-covered services.

\_\_\_\_\_ is voluntary insurance requiring a monthly premium. Beneficiaries pay a \_\_\_\_\_ and 80/20 \_\_\_\_\_ after the

\_\_\_\_\_ has been met for some services. There is no \_\_\_\_\_.

Medicare Part B covers:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ are managed care options for Parts A, B, and sometimes D through a private health plan, such as an HMO, PPO, Special Needs Plan (SNP), HMO Point of Service (HMO-POS) plan, or Medicare Medical Savings Account plan.

Most \_\_\_\_\_ offer coverage for things not paid by Original Medicare, such as vision, hearing, dental, and wellness programs (such as gym memberships). \_\_\_\_\_ may also cover over-the-counter drugs, transportation to doctor visits, adult day care services, and other health-related services promoting health and wellness.

\_\_\_\_\_ is health insurance for individuals with limited income and resources, funded jointly by the states and the federal government. It also covers services not normally covered by Medicare, such as long-term support and services and personal care services.

Individuals must also meet non-financial criteria to be eligible for \_\_\_\_\_. Beneficiaries generally must be \_\_\_\_\_. They must be either \_\_\_\_\_ or certain qualified, \_\_\_\_\_ such as \_\_\_\_\_.

Individuals with Medicare and full Medicaid coverage can receive benefits for services Medicare does not cover or only partially covers, including:

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is an earned benefit like the Social Security retirement benefit. It is \_\_\_\_\_ to individuals who cannot work due to a physical or mental disability.

\_\_\_\_\_ is a need-based program that provides \_\_\_\_\_ to disabled individuals with limited income and resources. Individuals eligible for \_\_\_\_\_ are also eligible for \_\_\_\_\_.

<b>Comparison of Public Benefit Programs</b>				
<b>Benefit type</b>	<b>Medicare</b>	<b>Medicaid</b>	<b>SSDI</b>	<b>SSI</b>
<b>Benefits based on</b>				
<b>Financed by</b>				
<b>Income/resource limit for eligibility</b>				
<b>Work credits required</b>				
<b>Basis for benefit amount</b>				

\_\_\_\_\_ is a healthcare program for military members, retirees, and their families.

TRICARE offers three basic options for care:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is supplemental insurance for military retirees and their dependents who are eligible for Medicare. It is Medicare wraparound coverage for \_\_\_\_\_ beneficiaries with Medicare Part A and Part B, covering deductibles, copayments, and coinsurance for Medicare-covered services.

\_\_\_\_\_ is for veterans who have served active duty in the military, meet specific length of service requirements, and were discharged under conditions other than dishonorable.

An \_\_\_\_\_ is a group of healthcare providers, including primary care physicians, specialists, and hospitals, that collaborate to deliver high-quality, coordinated care to the Medicare fee-for-service beneficiaries they serve.

Key components of the ACO model of care are:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ link the patient to the provider and/or service and include several types, such as a \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

### Preferred provider organization (PPO)

\_\_\_\_\_ contract with medical providers to deliver care to members at a discounted rate. The providers are listed as “preferred” or “in-network,” and their services receive better coverage under the \_\_\_\_\_, resulting in less out of pocket cost for the member.

An \_\_\_\_\_ is like a PPO: A network of providers agrees to provide care for members at a discounted rate. But \_\_\_\_\_ members who choose to receive care outside the EPO aren’t reimbursed for these outside services.

A \_\_\_\_\_ allows a patient to choose to receive in-network care at little or no cost, or to go out of the network and incur larger out-of-pocket expenses. This allows for flexibility in changing to and from in-network and out-of-network care at any time.

\_\_\_\_\_ reimburse providers by capitation, paying a fixed amount per member per month for contracted services.

There are four types of HMOs:

\_\_\_\_\_ – The HMO contracts with a multi-specialty physician group..

\_\_\_\_\_ – Like the group model, but the network model involves multiple groups of physicians and other providers to form a network of care.

\_\_\_\_\_ **model** – The HMO contracts with physicians who own their individual or group practices to provide care to HMO members.

\_\_\_\_\_ **model** – HMO physicians are employed by the HMO and provide services exclusively to its members.

\_\_\_\_\_ is insurance for employees who are injured, ill, or disabled as a direct result of their jobs.

Workers' compensation covers:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ **Act** – Provides workers' compensation for non-military federal employees

\_\_\_\_\_ **Act (FELA)** – Ensures that railroads engaged in interstate commerce are liable for injuries to their employees if they have been negligent

\_\_\_\_\_ **Act (LHWCA)** – Provides workers' compensation to specified employees of private maritime employers

\_\_\_\_\_ **Act** – Compensates miners suffering from "black lung."

Reimbursement and payment methods can be categorized according to payment basis:

- Service provided
  - \_\_\_\_\_
- Diagnosis or procedure
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
- Outcome
  - \_\_\_\_\_
- Financial risk
  - \_\_\_\_\_
  - \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_ Both involve a single payment for all services related to a specific treatment or condition over a defined period.

\_\_\_\_\_ is used primarily by the federal government to reimburse for care given to Medicare and Medicaid participants. \_\_\_\_\_ (not services) are reimbursed at a predetermined, fixed amount based on the typical cost to treat a given diagnosis. \_\_\_\_\_ (DRG) organize diagnoses according to cost.

\_\_\_\_\_ rewards providers, including hospitals and physicians, for delivering high-quality care that improves health outcomes.

Financial risk models can include:

- \_\_\_\_\_, where providers share in savings when they keep costs below a predetermined benchmark through efficient care management
- \_\_\_\_\_, where providers may incur losses if costs exceed benchmarks
- \_\_\_\_\_, where the provider or organization takes on more risk by agreeing to receive a set payment per member per month (PMPM) from the payer for specified medical services

Successful negotiations are based on \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

The negotiation was successful when \_\_\_\_\_ has been reached.

A \_\_\_\_\_ is a contract between an insurance company and an out-of-network healthcare provider. It enables a \_\_\_\_\_

to receive care from the \_\_\_\_\_ and be reimbursed as if it were \_\_\_\_\_.

\_\_\_\_\_ list reimbursement rates for specific procedures or services a health plan will pay.

When negotiating fee schedules:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is a process to ensure that services are provided at or above quality standards, at the appropriate and least costly level of care, and are medically necessary. CMS defines \_\_\_\_\_ as “services or supplies that: are proper and needed for the \_\_\_\_\_ or \_\_\_\_\_ of a medical condition, are provided for the \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ of a medical condition, meet the \_\_\_\_\_ in the local area, and \_\_\_\_\_ of the patient or doctor” (Watson, 2018).

Determining medical necessity of a procedure or level of service is often \_\_\_\_\_.

\_\_\_\_\_, or precertifications, occur prior to an elective admission or procedure, to ensure the requested service is necessary, meets the criteria for coverage, and is at the appropriate level of care.

\_\_\_\_\_ are conducted as the care is occurring to validate the necessity of continuing care and to explore lower levels of care alternatives.

A \_\_\_\_\_ is conducted on medical records after a client is discharged. It is conducted to track the appropriateness of care and utilization of resources.

\_\_\_\_\_ transforms client care services, procedures, and diagnoses into universal medical alphanumeric codes guided by coding manuals.

The \_\_\_\_\_ code is the diagnosis/reason for the encounter with the health system (e.g., chest pain, pre-op evaluation, diabetes).

\_\_\_\_\_ codes are a standardized form of identifying services provided, including medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management services.

To differentiate, an \_\_\_\_\_ code identifies the reason for the visit (e.g., chest pain), and a \_\_\_\_\_ code identifies procedures performed (e.g., evaluation and management, venipuncture, ECG).

A \_\_\_\_\_ is a patient classification system that CMS and some private insurers use to determine hospital payment for inpatient services. Instead of paying for each individual service or hospital day, the hospital receives a \_\_\_\_\_ based on the patient's \_\_\_\_\_.

The \_\_\_\_\_, published by the American Psychiatric Association (APA), is a comprehensive reference for classifying and diagnosing mental health disorders.

## Waiver programs

\_\_\_\_\_ allow states to provide standard medical and non-medical services at home and in the community to people who would otherwise be in an institution, nursing home, or hospital.

Services covered may include, but are not limited to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_, also known as the TEFRA Waiver, enables severely disabled children and young adults to be cared for at home *and* be eligible for Medicaid based on the affected individual's income and assets alone.

A \_\_\_\_\_ trust (SNT) is designed for beneficiaries who are disabled physically or mentally. SNTs can be tailored to meet the unique circumstances of each family.

Types of SNTs include:

\_\_\_\_\_ **SNT** – Designed to be the beneficiary's primary or sole source of benefits. It can make the beneficiary ineligible for needs-based benefits.

\_\_\_\_\_ **SNT** – Designed as a secondary source of benefits after government benefits have been exhausted.

Some life insurance policies have an \_\_\_\_\_ rider, which allows an insured person with a terminal illness or severe disability to use some of the policy's benefits before dying.

In a \_\_\_\_\_, a terminally ill person with limited life expectancy sells his life insurance policy to a third party for cash.

A homeowner age 62 or older may consider a \_\_\_\_\_, in which he borrows against his home's value without having to leave the home or make payments to the bank.

# Chapter 4: Psychosocial Concepts and Support Systems

Barriers to effective communication include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The following five conflict resolution strategies are listed from most to least desirable for most situations. The situation will dictate the best strategy.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

\_\_\_\_\_ describe how members of a group relate to each other and how the group relates to outsiders. They include how group members \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_, all impacting the group's performance and effectiveness.

Elements influencing group dynamics include:

\_\_\_\_\_ – How group members' responsibilities are defined

\_\_\_\_\_ – The acceptable standards of behavior within the group that group members share

\_\_\_\_\_ – The level of trust and collaboration among members

\_\_\_\_\_ – Whether communication is open, transparent, and accountable, or unclear, characterized by misunderstandings and conflict

There are five stages of group development: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

By the end of the \_\_\_\_\_ stage, ground rules and goals have been established.

Navigating the \_\_\_\_\_ stage requires effective communication and conflict resolution skills to clearly define roles and establish responsibilities so that the team can move forward cohesively.

In stage three, \_\_\_\_\_, the group establishes norms for interaction and develops stronger relationships.

In stage four, \_\_\_\_\_, group members work collaboratively toward shared goals.

The fifth and final stage, \_\_\_\_\_, occurs when the team's work concludes.

\_\_\_\_\_ involves obtaining, communicating, processing, and understanding health information, and applying that knowledge to real-life health situations.

Formal health literacy instruments include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ include \_\_\_\_\_ (SDoH), \_\_\_\_\_, and \_\_\_\_\_, which are interconnected and significantly impact health outcomes across populations.

\_\_\_\_\_ are non-medical factors that significantly influence health outcomes positively or negatively.

\_\_\_\_\_ refers to the fair and just opportunity to attain optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Centers for Medicare & Medicaid Services, 2024).

Promoting health equity includes \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_, such as structural racism and discrimination.

\_\_\_\_\_ are experiences or situations that create a higher burden of illness, injury, disability, or mortality for one group relative to another due to healthcare inequities. Examples include \_\_\_\_\_ services, \_\_\_\_\_, or \_\_\_\_\_.

\_\_\_\_\_ describe health factors at the population level. \_\_\_\_\_, on the other hand, bring these factors down to the individual and family levels by identifying the adverse social conditions that directly impact a specific individual's health outcomes. Among the most widely used HRSN screening tools are the \_\_\_\_\_ tool, \_\_\_\_\_ and the \_\_\_\_\_ tool.

Many people face barriers that prevent or limit access to healthcare, such as lack of \_\_\_\_\_, poor access to \_\_\_\_\_, and limited \_\_\_\_\_.

Resources to address healthcare access

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Resources to address access to healthy food

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Resources to address housing instability

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Resources to address utility needs

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

An individual must have sufficient \_\_\_\_\_ to legally give consent.

The \_\_\_\_\_ is a quick assessment to screen for cognitive impairment, Alzheimer's, and related dementia.

The \_\_\_\_\_ is a screening assessment of cognitive function. It consists of 11 questions. The test takes approximately 10 minutes to administer and is useful in assisting with the diagnosis of cognitive impairment following a \_\_\_\_\_, or the presence of \_\_\_\_\_. It is also used to assess the \_\_\_\_\_ and \_\_\_\_\_ of cognitive impairment.

The \_\_\_\_\_ screening tool takes 10-15 minutes to administer and evaluates multiple cognitive domains—attention, memory, executive function, language, visuospatial skills, and orientation—to detect mild cognitive impairment or early dementia. It is considered more \_\_\_\_\_ than other screening methods for identifying subtle cognitive changes.

The \_\_\_\_\_ is a comprehensive assessment of memory function administered by a trained professional, typically a psychologist or neuropsychologist. The \_\_\_\_\_ uses several subtests to measure different types of memory: immediate, delayed, auditory, visual, and working memory. It helps identify \_\_\_\_\_ and can distinguish between different causes of memory problems, such as Alzheimer's disease or traumatic brain injury.

The \_\_\_\_\_ is a structured assessment to evaluate a person's capacity to make informed decisions about medical treatment.

The \_\_\_\_\_ is a concise, structured guide that assists clinicians, nurses, social workers, and other healthcare team members in determining whether a patient has the \_\_\_\_\_ to make informed treatment decisions. Like the \_\_\_\_\_, the \_\_\_\_\_ looks at understanding, appreciation, and reasoning about medical choices, but it is less detailed and typically faster to administer.

The 5 Stages of Change

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

The \_\_\_\_\_ explains how clients' perceptions of health risks and the benefits of taking action influence their readiness to change. It theorizes people are more likely to change if they:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Client \_\_\_\_\_ describes the knowledge, skills, ability, willingness, and confidence a person has that allows him to become actively engaged in managing his health and healthcare.

The \_\_\_\_\_ was developed to measure a client's activation level.

Ways to increase activation include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ occurs when case managers support and educate clients and their support systems so they understand and can access quality, efficient healthcare.

\_\_\_\_\_ builds on client activation (mentioned previously) with behaviors such as maintaining a healthy diet, exercising regularly, or obtaining preventative care. Where the \_\_\_\_\_ client has the knowledge, skills, resources, and confidence to manage his diabetes, the \_\_\_\_\_ client monitors his blood sugars, maintains his diet, and exercises daily.

Factors that can impact client engagement include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ represents the ultimate goal: the client's ability to manage his health condition and make informed decisions about care.

Case managers support self-care management by:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The case manager has several tools and techniques to build trust, foster collaboration, and promote client engagement. These include \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

\_\_\_\_\_ forms the foundation for all client interactions, fostering relationships and understanding while facilitating cooperation and collaboration.

To incorporate active listening:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Building on active listening and interviewing skills, the \_\_\_\_\_ is a collaborative, client-centered approach that focuses on helping the client discover his motivation for change by identifying, examining, and resolving the client's ambivalence toward change.

Principles of motivational interviewing include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The basic approach used in motivational interviewing can be remembered by the acronym OARS:

**O** \_\_\_\_\_

**A** \_\_\_\_\_

**R** \_\_\_\_\_

**S** \_\_\_\_\_

Motivational interviewing is designed to avoid \_\_\_\_\_. Instead, it focuses on \_\_\_\_\_ and \_\_\_\_\_ between the client and the case manager, which builds trust.

\_\_\_\_\_ ensures all decisions and interventions are "respectful of and responsive to individual patient preferences, needs, and values" and that these values guide all clinical decisions (Institute of Medicine, 2001, p. 3).

The case manager provides person-centered care by:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ in case management uses a person-centered, collaborative approach between the case manager and client to ensure goals are meaningful and achievable.

The SMART acronym helps ensure goals are:

**S** \_\_\_\_\_

**M** \_\_\_\_\_

A \_\_\_\_\_

R \_\_\_\_\_

T \_\_\_\_\_

\_\_\_\_\_ utilizes all the above tools and techniques—active listening, motivational interviewing, person-centered care, and collaborative goal setting—in a proactive approach to managing care for clients with chronic illness.

Health coaching focuses on \_\_\_\_\_, meaning the aim is to lessen the impact of a chronic disease the client already has.

\_\_\_\_\_ recognizes the impact of trauma on well-being and creates a safe, supportive, and empowering environment that promotes healing and recovery.

The six core principles of trauma-informed care are:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The HEAR technique provides a structured approach for trauma-informed communication:

H \_\_\_\_\_

E \_\_\_\_\_

A \_\_\_\_\_

R \_\_\_\_\_

Barriers to healthcare for LGBTQ+ individuals include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Culture consists of \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

A \_\_\_\_\_ assessment, including an assessment of the client's linguistic needs, should be included in the case manager's initial client assessment.

Sometimes, these \_\_\_\_\_ conflict with the treatment plan. When this happens, the case manager should attempt to \_\_\_\_\_. If this is not possible, the case manager must educate the client on the \_\_\_\_\_.

When using an interpreter, it is best to use a \_\_\_\_\_ whenever possible.

\_\_\_\_\_ tend to improve coping skills, provide optimism and hope, promote healthy behavior, decrease feelings of depression and anxiety, and encourage a sense of relaxation.

By relieving stressful feelings and promoting healing, \_\_\_\_\_ can positively influence the immune, cardiovascular, hormonal, and nervous systems.

A chronic illness or disability can alter a client's \_\_\_\_\_ and \_\_\_\_\_.

\_\_\_\_\_ is a person's belief in his ability to succeed and plays a crucial role in one's willingness to adapt and persist in the face of challenges.

For a behavioral change to take hold, the client must:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Several factors influence self-efficacy, including:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Case managers play a vital role in fostering self-efficacy by:

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ is usually his primary source of support and, when necessary, his caregiver. \_\_\_\_\_ provide most long-term care for patients. To best serve the client, case managers need to provide support and advocacy for \_\_\_\_\_ and the \_\_\_\_\_.

Case managers must also consider the \_\_\_\_\_, as preexisting challenges can affect a family's ability to adjust to a health-related disruption.

\_\_\_\_\_ can adjust to these changes and help clients reach their goals.

An adaptive family possesses the ability to:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ struggle to meet the changing needs of the family.

These families may:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ assists cancer patients with local transportation to and from treatments and appointments, lodging when traveling for care away from home, and online support groups, among many other resources.

Support programs are also available for \_\_\_\_\_.

Both \_\_\_\_\_ and \_\_\_\_\_, such as the Alzheimer's Foundation of America, offer local support groups that provide education, coping strategies, and support services for caregivers.

\_\_\_\_\_ and \_\_\_\_\_ help individuals cope with the loss of a loved one as well as other significant losses caused by illness, disability, or major life changes.

Substance use does not equate to \_\_\_\_\_.  
The \_\_\_\_\_

\_\_\_\_\_ defines substance use disorder as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within 12 months:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

The \_\_\_\_\_ tool is available for screening substance use disorder. It consists of four questions:

Levels of care for addiction are based on a program's structure, including the setting, intensity, and frequency of services.

**Level I:** \_\_\_\_\_

**Level II:** \_\_\_\_\_

**Level III:** \_\_\_\_\_

**Level IV:** \_\_\_\_\_

\_\_\_\_\_, or \_\_\_\_\_ disorders, describes patients with coexisting mental illness and substance use disorders.

The mental illness must meet the criteria for diagnosis by the \_\_\_\_\_.

A \_\_\_\_\_ is any situation in which the client perceives the inability to effectively problem-solve or cope.

Never \_\_\_\_\_ until \_\_\_\_\_ is established.

If the client is thought to be at risk for suicide, the case manager should \_\_\_\_\_  
\_\_\_\_\_. Remove items such as \_\_\_\_\_  
or \_\_\_\_\_ from the client's access.

De-escalation techniques use verbal and nonverbal communication to stabilize the  
client, \_\_\_\_\_ and \_\_\_\_\_, and \_\_\_\_\_. They include \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_,  
and providing \_\_\_\_\_.

After ensuring safety, use \_\_\_\_\_ to assess the client's state  
of need.

While guiding the client through this process, work together to create a \_\_\_\_\_  
\_\_\_\_\_. This plan should \_\_\_\_\_, incorporate the  
\_\_\_\_\_ discussed, and include \_\_\_\_\_.

While abuse and neglect can happen to anyone, specific populations are particularly  
vulnerable, including \_\_\_\_\_, \_\_\_\_\_, and  
\_\_\_\_\_.

#### Signs of physical abuse

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Signs of emotional/psychological abuse

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Signs of neglect

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Signs of sexual abuse

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Many case managers are \_\_\_\_\_ of abuse or neglect based on their primary discipline. They must notify the \_\_\_\_\_ if abuse or neglect is suspected.

# Chapter 5: Quality and Outcomes Evaluation and Measurements

The \_\_\_\_\_ process is conducted by an external organization, in which trained peer reviewers evaluate a healthcare organization's compliance with nationally accepted quality standards and the accrediting body's own performance standards.

Although \_\_\_\_\_ is technically voluntary, Medicare, Medicaid, and many third-party payers often require \_\_\_\_\_ before reimbursing for healthcare services.

\_\_\_\_\_ is regarded as one of the key benchmarks for measuring an organization's quality.

Each \_\_\_\_\_ determines its standards and requirements based on its corner of the healthcare industry.

The \_\_\_\_\_ is the federal agency that oversees healthcare facilities participating in Medicare and Medicaid programs.

CMS establishes \_\_\_\_\_, which outline the requirements healthcare organizations must meet to receive reimbursement from Medicare and Medicaid. The requirements include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Healthcare organizations must be certified as complying with \_\_\_\_\_ to be reimbursed by CMS.

Case managers' roles in CMS CoPs compliance:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ accredits various healthcare settings, including hospitals, ambulatory care centers, behavioral health facilities, home care, nursing care centers, and laboratories.

\_\_\_\_\_ accreditation standards focus on patient safety, quality care, and organizational leadership and governance.

To ensure continuous compliance, \_\_\_\_\_ surveys are typically unannounced. \_\_\_\_\_ uses tracer methodology, in which surveyors evaluate patient care by reviewing patients' movements throughout the system.

The \_\_\_\_\_ provides accreditation for case management, utilization management, long-term support services (LTSS), and health plans, among others.

The core of the \_\_\_\_\_ accreditation program is care coordination, patient-centeredness, and quality of care.

NCQA's case management accreditation focuses on:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_, in the form of anecdotal information (or stories), helps to identify potential issues. \_\_\_\_\_ confirms or contradicts anecdotes, highlights the severity of issues, and provides insight for potential solutions.

Case management programs should promote \_\_\_\_\_ and \_\_\_\_\_ of services rendered. They should keep written documentation of their \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_. \_\_\_\_\_ related to case management services and \_\_\_\_\_ should be tracked, and steps taken to enhance areas needing improvement.

\_\_\_\_\_ is the foundation of quality improvement and performance improvement projects, so ensuring the \_\_\_\_\_ is \_\_\_\_\_ and \_\_\_\_\_ is critical.

\_\_\_\_\_ refers to the meaningfulness of the data being measured; is it measuring what it intends to measure? \_\_\_\_\_ refers to the accuracy of the data.

\_\_\_\_\_ data is non-numerical, descriptive, and based on observations, interviews, or experiences.

\_\_\_\_\_ is numerical, standardized, and objective, making it more valid and usually preferred over qualitative data.

After data is collected, it is interpreted, which is the process of \_\_\_\_\_ to the information and \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ of the findings.

Once again, it is essential to avoid \_\_\_\_\_ when interpreting the data.

Quality improvement and performance improvement aim to improve how things are done. They can be prospective or retrospective.

\_\_\_\_\_ is the systematic, data-driven effort to measure and improve client services and the quality of healthcare services. It is accomplished by \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ quality deficiencies and noncompliance with the standards of care.

\_\_\_\_\_ focuses on a healthcare organization's functions and processes and their effect on desired outcomes and meeting clients' needs.

Performance improvement measures usually fall into one of three categories:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ are metrics for assessing and monitoring the quality and outcomes of care and services. To be effective, indicators must be \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

Examples of utilization indicators include:

- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Examples clinical indicators include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Examples of productivity include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Examples of financial indicators include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Case managers show the financial value of case management in the \_\_\_\_\_, which formally documents the reduction in healthcare costs attributable to case management involvement and interventions. It accounts for \_\_\_\_\_ and \_\_\_\_\_ cost savings. \_\_\_\_\_ savings are directly related to the case manager’s actions; examples include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ cost savings are *potential* savings—costs avoided due to case management intervention.

Soft cost savings may include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Cost savings = \_\_\_\_\_ Costs – ( \_\_\_\_\_ Cost + Cost of \_\_\_\_\_ )

The \_\_\_\_\_ (HCAHPS, pronounced "H-caps") is a nationally standardized hospital survey of patients' perspectives of their hospital experience, developed by CMS

The Deficit Reduction Act of 2005 requires hospitals subject to the Inpatient Prospective Payment System (IPPS) annual payment update provisions to collect and submit \_\_\_\_\_ data to receive their full IPPS annual payment update. The Affordable Care Act also included \_\_\_\_\_ among the measures used to calculate value-based incentive payments in the Hospital Value-Based Purchasing program.

\_\_\_\_\_ sponsors, supports, and maintains a collection of standardized performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS). \_\_\_\_\_ enables reliable comparisons of healthcare quality across health plans for consumers, purchasers, and regulators.

HEDIS consists of numerous measures in six domains of care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

\_\_\_\_\_ case management and workers' compensation case management standards cover eight domains: risk management, operations and infrastructure, performance monitoring and improvement, consumer protection, staff qualifications and training, measure reporting, and the specifics of the case management program and the workers' compensation case management program.

\_\_\_\_\_ are standardized performance measures used to assess and improve healthcare quality in the United States. These indicators are \_\_\_\_\_ tools that evaluate various aspects of healthcare delivery, including structure, process, outcomes, and patient perceptions.

Once \_\_\_\_\_ endorses a measure, it can be used by hospitals, healthcare systems, and government agencies, like CMS, for public reporting and quality improvement.

\_\_\_\_\_ quality indicators (QIs) are standardized, evidence-based healthcare quality measures compiled from hospital inpatient administrative data.

The performance data \_\_\_\_\_ uses include: administrative data, such as billing or claims information; medical record information; patient-derived data such as surveys; confidential provider reports; and direct observation.

The QIs consist of four models measuring various aspects of quality

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

The \_\_\_\_\_ is defined by a 3-6-9 strategy, a set of three overarching aims building on the Triple Aim, six priorities of common health concerns, and nine levers to align business/organizational functions and drive quality improvement.

### Three overarching aims

The \_\_\_\_\_ provide guidance and set goals at all levels for improving health and healthcare quality.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

The \_\_\_\_\_ creates a financial incentive for hospitals to reduce readmissions by improving discharge planning and follow-up care (core case management responsibilities). Through the program, \_\_\_\_\_ penalizes hospitals with excessive unplanned readmissions compared to similar hospitals, for the conditions listed below.

HRRP tracks 30-day unplanned readmission rates for:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ Program incentivizes hospitals to give better care (rather than treat more patients) by reimbursing based on quality of care metrics.

The program measures hospital care performance in four areas:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Case managers play a crucial role in value-based care through practices that directly influence \_\_\_\_\_ and \_\_\_\_\_.

Case management practices impacting value-based care include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ model asks three questions:

1. \_\_\_\_\_ – The team identifies the issue and sets time-specific, measurable goals.
2. \_\_\_\_\_ – The team determines what data will determine if the change creates improvement.
3. \_\_\_\_\_ – Suggestions from all stakeholders must be considered.

In the \_\_\_\_\_ approach, the \_\_\_\_\_ stage identifies a process that has yielded less-than-ideal outcomes. The \_\_\_\_\_ stage measures key performance attributes. \_\_\_\_\_ devises a new approach, and \_\_\_\_\_ integrates the redesigned approach into the process.

\_\_\_\_\_ is a data-driven methodology used in healthcare to measure and improve patient outcomes, increase efficiency, and reduce costs while increasing patient satisfaction. \_\_\_\_\_ focus is identifying and eliminating \_\_\_\_\_ and i\_\_\_\_\_ in processes and practices, from patient care to administrative tasks.

\_\_\_\_\_ uses a 5-step approach to process improvement, known by the acronym DMAIC:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

The \_\_\_\_\_ to quality improvement emphasizes eliminating waste to increase value.

Waste is identified as one of 8 areas, using the acronym DOWNTIME.

**D:** \_\_\_\_\_

**O:** \_\_\_\_\_

**W:** \_\_\_\_\_

**N:** \_\_\_\_\_

**T:** \_\_\_\_\_

**I:** \_\_\_\_\_

**M:** \_\_\_\_\_

**E:** \_\_\_\_\_

Lean provides tools for analyzing process flow and delay times to distinguish “\_\_\_\_\_ - \_\_\_\_\_” work from “\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_” work. When the non-value-added work (or “\_\_\_\_\_”) is identified, it is eliminated.

\_\_\_\_\_ and \_\_\_\_\_ can be combined in a “\_\_\_\_\_” event, merging both philosophies.

\_\_\_\_\_ events are team exercises, in which a process is taken apart and mapped, and opportunities for improvement are identified.

Kaizen activities cycle through seven phases:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

\_\_\_\_\_ visually represents the sequence of steps in a workflow or process (e.g., documentation workflow, hospital discharge process) to identify delays, duplications, bottlenecks, or gaps.

\_\_\_\_\_ are based on the Pareto principle, which states that \_\_\_\_ percent of effects come from \_\_\_\_ percent of causes. They help prioritize improvement efforts by \_\_\_\_\_(s) responsible for most problems among the many identified.

\_\_\_\_\_ examine relationships between two variables to identify potential correlations.

A \_\_\_\_\_ is a process to calculate and compare the cost and benefits of interventions, services, or treatments in monetary terms. It provides a comprehensive assessment of healthcare interventions by considering both health and non-health benefits to determine whether \_\_\_\_\_.

### Elements of cost-benefit analysis

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is "a performance measure used to evaluate the benefit (e.g., quality outcomes, revenue, and cost savings) of a product, service, or intervention, such as case management relevant to its related expenses (cost). The result is expressed as a percentage or ratio" (CCMC Glossary of Terms, 2022).

The formula is:

ROI = ( \_\_\_\_\_ / \_\_\_\_\_ ) × 100%, where

- \_\_\_\_\_ = total benefits - total costs
- \_\_\_\_\_ = Total investment in the intervention

\_\_\_\_\_ use data and statistics to identify at-risk individuals who may benefit from case management services. The tools \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

A \_\_\_\_\_ is a tool for assessing a patient's health status, risk of adverse health outcomes, and readiness to change certain behaviors.

The Affordable Care Act requires that an \_\_\_\_\_ be included in the annual wellness visit for Medicare beneficiaries, and that it must identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs.

\_\_\_\_\_ uses technology to statistically analyze enormous amounts of data (often retrieved from health plan claims) to predict outcomes for individual patients.

The \_\_\_\_\_ system is a tool that uses the diagnostic and pharmaceutical code information from insurance claims and electronic medical records to measure morbidity in large populations based on disease patterns, age, and gender.

Unlike many traditional methods of identifying clients for case management, such as emergency department usage, hospitalization, or high-dollar claims, the \_\_\_\_\_ identifies individuals likely to *become* high-resource users.

# Chapter 6: Rehabilitation Concepts and Strategies

\_\_\_\_\_ is a standardized assessment tool used across post-acute care settings, including long-term acute care (LTAC) hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health, to evaluate a client's self-care and mobility abilities. \_\_\_\_\_ provides a standardized scoring algorithm for specific \_\_\_\_\_ and various \_\_\_\_\_ tasks.

Self-care activities measured:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Mobility items measured:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
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- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ activities are scored according to the level of assistance from a \_\_\_\_\_ required.

The scoring is scaled as follows:

6 / \_\_\_\_\_ – Completes the activity safely \_\_\_\_\_ assistance

5 / \_\_\_\_\_ – Completes the activity \_\_\_\_\_

4 / \_\_\_\_\_ – Requires \_\_\_\_\_

/ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3 / \_\_\_\_\_ – Helper does \_\_\_\_\_

\_\_\_\_\_ effort

2 / \_\_\_\_\_ – Helper \_\_\_\_\_

\_\_\_\_\_ the effort

1 / \_\_\_\_\_ – \_\_\_\_\_ assistance or assistance required

\_\_\_\_\_

\_\_\_\_\_ are tools designed, made, or adapted to help individuals perform a specific task. \_\_\_\_\_ refers to any item, product, system, or piece of equipment used to increase, maintain, or improve the functional capabilities of individuals with disabilities.

\_\_\_\_\_ support individuals with mobility impairments by helping them move safely and in various settings.

Telecommunication devices for people who are deaf or hard of hearing (referred to generally as TDD, or telecommunication device for the deaf) include:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is specialty healthcare for individuals who have experienced physical impairments or disabilities due to illness, injury, or medical conditions. \_\_\_\_\_ restores, enhances, or maintains their functional abilities.

\_\_\_\_\_ – An outpatient program for clients who no longer require hospitalization but still need intensive, coordinated rehabilitation for several hours per day.

\_\_\_\_\_ – 30- to 60-minute therapy sessions per discipline provided in a clinic or hospital outpatient setting.

\_\_\_\_\_ – Therapy provided in the client's home for up to one hour per discipline per visit. Visits occur up to three times per week.

### Substance use rehabilitation treatment settings

\_\_\_\_\_ – 24/7 care in a structured environment, short-term (28 days to 6 months) or long-term (6 to 12 months)

\_\_\_\_\_ – Intensive treatment during the day, returning home in the evenings

\_\_\_\_\_ – More structured than standard outpatient care, typically involving several hours of treatment per week

\_\_\_\_\_ – Individuals live at home while attending scheduled treatment sessions

\_\_\_\_\_ programs support students with special needs in their education environment. They help students \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_

in school, ensuring they can fully participate in their education and reach their potential.

Inpatient rehabilitation may be provided in the following settings:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ setting is for patients with acute medical needs.

Medical hospital care is delivered in two types of hospitals: \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_.

LTACs are more specifically designated for clients with \_\_\_\_\_ medical needs, such as \_\_\_\_\_,

wound care, or \_\_\_\_\_ medications, that require ongoing hospital-level care. LTAC-specific case manager responsibilities include \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ as the patient's condition improves.

\_\_\_\_\_ primarily provide intense, multidisciplinary therapy to patients with functional loss (e.g., after a stroke).

\_\_\_\_\_ provide rehabilitation services, such as physical, occupational, and speech therapy, at less-intense levels than inpatient rehabilitation hospitals, to patients who cannot tolerate three hours of therapy per day.

Case managers lead or participate in interdisciplinary team meetings during which they \_\_\_\_\_, confirm \_\_\_\_\_, address \_\_\_\_\_, and identify \_\_\_\_\_.

Case managers \_\_\_\_\_ among the patient, family, and care team on recovery goals, discharge planning, and post-discharge care.

Rehab case manager transitions of care coordination responsibilities include:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

The two most frequently reported reasons for difficulty obtaining employment for people with disabilities are \_\_\_\_\_ and \_\_\_\_\_.

Many individuals need \_\_\_\_\_, such as accessible parking or transportation, elevators, or specially designed workstations.

Rehabilitation for people with disabilities (PWD) and chronic illnesses is a continuous and adaptive process that embraces a \_\_\_\_\_.

Care is tailored to the individual's unique needs, considering \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ affecting health.

Rehabilitation extends beyond medical care to include \_\_\_\_\_, which promotes interaction and integration with the

community; \_\_\_\_\_ to adapt living spaces, improving safety and independence; and \_\_\_\_\_, assisting with job placement and workplace integration.

\_\_\_\_\_ is a process to identify, in detail, the essential duties and requirements for a given job, and their relative importance. \_\_\_\_\_ focuses on the job itself, not the person occupying the role (Chapin et al., 2018).

The \_\_\_\_\_ enables the development of a training plan, work modification, or reasonable accommodation for the individual that will make it possible for them to fulfill the requirements of the job.

\_\_\_\_\_ and \_\_\_\_\_ include any change in the environment or how tasks are customarily completed that enables a PWD to perform the task or accomplish a goal (Chapin et al., 2018).

A \_\_\_\_\_ is an across-the-board change to the job description or how tasks are done, targeting skills.

\_\_\_\_\_ are individualized and focus on access, such as voice recognition software or a desk that rises to accommodate a wheelchair.

The \_\_\_\_\_ is a consulting service provided by the U.S. Department of Labor's Office of Disability Employment Policy (ODEP) that provides free information on job accommodations.

More than half of all accommodations cost \_\_\_\_\_, and most of the rest cost less than \$\_\_\_\_\_.

The ADA lists six categories of accommodations:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is paid, competitive employment in an integrated workplace setting, with ongoing support for individuals with the most severe disabilities.

\_\_\_\_\_ helps individuals obtain, perform, and retain their jobs, in the form of job coaching, job placement, specialized job training, on-site assistive technology, transportation, help interacting with employers, and individually tailored supervision.

\_\_\_\_\_ provides a vehicle for eligible individuals to enter competitive employment where they would otherwise be unable to do so due to the impact of their disabling conditions.

\_\_\_\_\_ focuses on attitude, behavior, and social skills for clients with behavioral health issues.

\_\_\_\_\_ is an advanced practice for evaluating, coordinating, and monitoring necessary services, ensuring individuals with significant disabilities or illnesses receive comprehensive and coordinated lifelong care.

\_\_\_\_\_ are then customized for the individual's medical condition, life expectancy, and functional needs.

## Understand Types of Vocational Rehabilitation Programs and Resources

\_\_\_\_\_ programs assist individuals with health, functional, psychological, developmental, cognitive, and/or emotional limitations, injuries, or disabilities return to work and economic self-reliance in a prior or a new job.

\_\_\_\_\_ specialists provide group and individual counseling, help clients overcome psychological, developmental, cognitive, and health barriers, create job plans, and guide clients to achieve their employment goals.

\_\_\_\_\_ governments have eligibility-based career development programs to help individuals with disabilities acquire skills, attitudes, and resources needed to obtain and keep a job. To be eligible, federal regulations require an individual be \_\_\_\_\_ and \_\_\_\_\_ from vocational rehabilitation services. The disability must be a physical or mental impairment that is a \_\_\_\_\_ to employment. Those receiving \_\_\_\_\_ and/or \_\_\_\_\_

\_\_\_\_\_ are presumed eligible unless their disabilities are too severe for them to benefit from vocational rehabilitation (defined as being unable to achieve employment).

The voluntary \_\_\_\_\_ allows clients aged 18-64 who currently receive Social Security benefits based on disability under the SSDI and/or SSI programs to maintain their benefits while working and also provides expanded options for accessing employment services, vocational rehabilitation services, and other support services needed to enter, maintain, and advance employment.

After a work-related injury, the goal is for the worker to achieve \_\_\_\_\_ and to return to work as soon as possible.

The return-to-work options are evaluated in the following order:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

\_\_\_\_\_ is an individualized, highly structured program that focuses on work endurance by progressively increasing tolerance with conditioning exercises, including strengthening and flexibility exercises, cardiovascular conditioning, spine and joint stabilization exercises, and job task training such as pushing, pulling, bending, twisting, or lifting.

\_\_\_\_\_ is designed to restore systemic neurological, cardiopulmonary, and musculoskeletal functions to enable the injured worker to return to work. \_\_\_\_\_ differs from work hardening in that the focus is not on specific tasks the client must perform (for example, lifting a 20-pound box and placing it on a shelf) but rather on building the strength required to lift anything.

If the client has reached \_\_\_\_\_ and cannot perform the job's essential duties, with or without accommodation, a \_\_\_\_\_ can be completed to document current and projected employment based on the client's skills, abilities, and aptitude.

## Transitional work duty

\_\_\_\_\_ allows injured employees to return to productive work with their employer while under the care of rehabilitation professionals. The employer creates a \_\_\_\_\_ based on the employee's knowledge and skills.

# Chapter 7 Ethical, Legal, and Practice Standards

Case managers are held to the standards related to their \_\_\_\_\_ and the \_\_\_\_\_.

In addition to CMSA's Standards of Practice for Case Management, social worker case managers must adhere to the National Association of \_\_\_\_\_.

## American Nurses Association Scope and Standards of Practice

In addition to CMSA's Standards of Practice, nurse case managers must maintain the \_\_\_\_\_ and the \_\_\_\_\_ for all states where they hold a \_\_\_\_\_.

Board-certified case managers (CCMs) are held to the \_\_\_\_\_, which is frequently reviewed and revised.

CCMs must disclose \_\_\_\_\_ with clients, payers, employers, friends, relatives, research studies, or other entities. They must also maintain \_\_\_\_\_ with their clients and avoid \_\_\_\_\_, including \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ of \_\_\_\_\_.

CCMs must maintain objectivity in their professional relationships and not \_\_\_\_\_ on their clients.

Before discontinuing case management services, board-certified case managers will \_\_\_\_\_ to \_\_\_\_\_.

The case management process is carried out within the ethical and legal realms of a case manager's \_\_\_\_\_, using critical thinking and evidence-based knowledge (CMSA, 2024). Case managers must be knowledgeable about and follow all \_\_\_\_\_ related to their \_\_\_\_\_.

CCMs will practice only within the boundaries of their \_\_\_\_\_ or \_\_\_\_\_, based on their education, skills, and professional experience [and other professional credentials] (CCMC, 2023).

Professional case managers practice \_\_\_\_\_ and \_\_\_\_\_ sensitivity and maintain current knowledge of the diverse populations served so the services they provide are \_\_\_\_\_ and culturally and linguistically appropriate.

The *CMSA Standards of Practice* outlines ways case managers demonstrate cultural and linguistic sensitivity, including:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

The principle of \_\_\_\_\_ requires respecting and supporting the client's right to make his own healthcare decisions.

\_\_\_\_\_ requires case managers to take positive action to help the client and to do good.

\_\_\_\_\_ means to "do no harm," demonstrated in the case management emphasis on quality care outcomes.

The principle of \_\_\_\_\_ ensures fairness and equality in access to healthcare resources and treatment by others.

The principle of \_\_\_\_\_ requires case managers to keep their commitments and promises.

A U.S. law, the \_\_\_\_\_, embodies these principles by ensuring all patients have the right to agree to or refuse treatment (\_\_\_\_\_) and must be informed of the consequences of their decisions (\_\_\_\_\_).

The \_\_\_\_\_ also supports these ethical principles. It supports patient \_\_\_\_\_ by requiring all hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance

organizations that receive Medicare and Medicaid reimbursement to recognize the living will and durable power of attorney for healthcare.

The CMSA and the CCMC emphasize advocacy as a core component of a case manager's role. Case managers serve as advocates for their clients by:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

The case manager's role as a client advocate stems from the ethical principle of client \_\_\_\_\_. The client's needs, \_\_\_\_\_, are primary.

\_\_\_\_\_ identifies, evaluates, and takes corrective action against actual and potential risks that could lead to adverse events, financial or clinical losses, or legal liabilities. The goal of \_\_\_\_\_ is to reduce \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ while \_\_\_\_\_.

The risk management process includes:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ is a structured method for identifying what, how, and why an adverse event occurred. An \_\_\_\_\_ focuses on system failures rather than individual blame, as human error is inevitable, but systems can decrease or prevent the likelihood of an adverse event.

Root cause analysis contains four steps:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Case managers should maintain \_\_\_\_\_ and \_\_\_\_\_ in documentation. \_\_\_\_\_ may be recorded when appropriate.

CCMC's Code of Conduct requires CCMs to document \_\_\_\_\_ case management services. Documentation must be provided to \_\_\_\_\_ and \_\_\_\_\_ and \_\_\_\_\_ before discontinuing services.

Case closure documentation should include \_\_\_\_\_ and a \_\_\_\_\_. \_\_\_\_\_ provide a concise overview of a client's progress, interventions, and outcomes.

### Elements of a case summary

#### Client overview

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Interventions and care coordination

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Progress and outcomes

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Impact of case management services (important for purchasers of CM services)

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Next steps and ongoing needs

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

In workers' compensation (WC) case management, case summaries are often required to document an injured worker's \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_.

Additional elements for WC case summaries:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

If an employer's policies conflict with legal requirements, the \_\_\_\_\_ takes precedence.

A \_\_\_\_\_ occurs when a case manager refers a patient to an unqualified or incompetent provider.

The following criteria must be met for consent to be informed:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_ refers to a person's ability to make informed decisions and provide informed consent.

\_\_\_\_\_ is a legal term and process that determines if a person has the capacity to make decisions (usually business, financial, and medical) for him or herself.

Mandatory reporting laws vary by state but generally include:

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Nurse case managers must generally be licensed in the state where \_\_\_\_\_  
\_\_\_\_\_.

The \_\_\_\_\_ allows nurses to practice in all compact member states with one multistate license.

\_\_\_\_\_ consists of policies, procedures, training, and enforcement mechanisms to prevent misconduct and ensure compliance.

A compliance program should include the following elements:

- \_\_\_\_\_  
\_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
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\_\_\_\_\_, also known as the patient dumping statute, is a federal law that requires Medicare-participating hospitals that offer emergency services to provide the following to all individuals seeking emergency care:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities.

The ADA defines an individual with a disability as a person who:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The ADA protects \_\_\_\_\_, not \_\_\_\_\_.

\_\_\_\_\_ refers to a problem with a structure or organ of the body.

\_\_\_\_\_ is a functional limitation regarding a particular activity.

\_\_\_\_\_ refers to a disadvantage in filling a role in life relative to peers.

HIPAA is the Health Insurance Portability and Accountability Act of 1996. Title I of the Act guarantees health insurance \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_; eliminates some \_\_\_\_\_ clauses; and prohibits \_\_\_\_\_ based on \_\_\_\_\_.

HIPAA covers PHI \_\_\_\_\_, \_\_\_\_\_, or \_\_\_\_\_ outside the agency.

It is important to note that HIPAA \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, or \_\_\_\_\_ insurance and that state laws take precedence over HIPAA if they are stricter in protecting the privacy of medical records.

Under \_\_\_\_\_ General Duty Clause, employers must keep their workplaces free of serious recognized hazards.

Examples of OSHA standards include providing \_\_\_\_\_, preventing some \_\_\_\_\_, preventing exposure to harmful substances, and providing \_\_\_\_\_ for certain dangerous jobs.

While there is no specific OSHA standard addressing workplace violence, employers can be cited under the General Duty Clause for failing to protect workers from recognized violence hazards, including aggression from \_\_\_\_\_ or \_\_\_\_\_.

OSHA protects workers who report \_\_\_\_\_ from retaliation.

\_\_\_\_\_ provides eligible employees up to 12 weeks of unpaid leave a year for specified family and medical reasons

FMLA may be taken for:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The Women's Health and Cancer Rights Act requires that group health plans providing coverage for mastectomies also cover the following:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The ACA identified improvements to the often-fragmented healthcare system, such as the \_\_\_\_\_ and the \_\_\_\_\_.

Key aspects of the ACA.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Hospitals receive payment adjustments based on how well they perform on measures within four domains:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The Hospital Readmission Reduction Program monitors readmission for six conditions:

- \_\_\_\_\_
- \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Case managers specifically support value-based programs through:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

The \_\_\_\_\_ is a federal law protecting insured and uninsured individuals from unexpected medical bills.

The \_\_\_\_\_ bans surprise billing for most emergency services and limits out-of-network cost-sharing.

The No Surprises Act:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

At the beginning of the case manager-client relationship, CMs must inform their clients that although their \_\_\_\_\_ are \_\_\_\_\_, certain information obtained through the relationship may be disclosed to \_\_\_\_\_, such as \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_. Any information disclosed is limited to what is \_\_\_\_\_ and \_\_\_\_\_ (CCMC, 2023).

HIPAA \_\_\_\_\_ prevent the exchange of essential information but ensures it is done \_\_\_\_\_ and \_\_\_\_\_ (U.S. Department of Health and Human Services, 2022).

Legal and Regulatory Requirements Applicable to Case Management Practice.

One way case managers can avoid burnout is to \_\_\_\_\_ with \_\_\_\_\_ and \_\_\_\_\_. This involves defining

\_\_\_\_\_ of the case manager's \_\_\_\_\_ and \_\_\_\_\_, along with that of each stakeholder.

Although self-care is a personal matter that everyone approaches differently, some fundamental components exist, such as \_\_\_\_\_, engaging in \_\_\_\_\_, and participating in activities that give \_\_\_\_\_.