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What happens when you combine intuitive, creative, and emotional thinking with logical, rational, and analytical thinking? You've just created a human brain, with the right side taking on the artistic creativity and the left side being responsible for the scientific rationales. Case managers are constantly reminded that there is a balance between the two sides that must be maintained – through the use of critical thinking – for their work to be successful.

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By Mary Beth Newman, MSN, RN-BC, CMAC, CCP, CCM
We all take on numerous balancing acts in our lives, and juggling work responsibilities with family and personal life is probably one of the biggest balancing acts we do. But in the professional world of case management, there is a balancing act that is just as important — and that is balancing the art and the science of case management.

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An effective case manager is one who is flexible, creative, caring, and open-minded, has good active listening skills, is outcome focused, and is able to see and respond to the “big picture” for each patient.

We all take on numerous balancing acts in our lives, and juggling work responsibilities with family and personal life is probably one of the biggest balancing acts we do. But in the professional world of case management, there is a balancing act that is just as important — and that is balancing the art and the science of case management.

The science of case management involves anticipating an event or outcome and then applying the knowledge of what we know works. For example, we anticipate characteristics of patients that are most likely to benefit from case management services and target outreach efforts to that population. We anticipate what interventions are most likely to most benefit a patient by turning to valid clinical practice guidelines and comparative effectiveness research to guide our assessment, planning, monitoring, and evaluation efforts. We use medical management systems and software that capture assessment and care planning data so that outcomes can be effectively measured and analyzed.

The art of case management is all about the way we communicate and interact with our patients. The art of case management requires caring, compassion, empathy, mindfulness and being “in the moment” with the patient. The tools we use to advance the art of case management are active listening and meaningful conversations. When you think about it, case management is really about building relationships, and building relationships is all about having meaningful and personal conversations.

The art of case management also involves seeing the “big picture” of the patient’s current situation including strengths, barriers to adherence, psychosocial support, financial and environmental issues, family dynamics, and many other factors. These of course will be different for every individual, and thus we can’t rely on scientific evidence to present the “big picture” for us. This is where critical thinking – the art of active listening, thinking out of the box, and “connecting the dots” – comes into play.

The art and science aspects of case management truly work hand-in-hand. For example, conducting an assessment with a patient requires a perfect balance of art and science. We certainly need to use technology to drive a comprehensive, individualized, evidence-based assessment (the “science” part). However, we also need to be sure that we don’t fall into the trap of simply reading an endless list of questions to the patient and recording their answers. There needs to be time spent on establishing rapport and trust, which happens through relationship-building conversations (the “art” part). In fact, asking open-ended questions and actively listening and responding to the patient’s answers can provide most of the information needed for any assessment!

The art of conversation quickly becomes a lost art when a case manager is focused on how quickly all the boxes and fields on an assessment can be clicked on and filled in. An organization that measures case management “productivity” on this basis alone is missing the mark and undermines the value that meaningful and personal conversation plays in achieving successful outcomes.

Case management requires a number of elements working in unison and harmony to achieve successful outcomes. Effectively applying the case management process involves both art and science. Critical thinking is truly the bridge between the art and science of case management. An effective case manager is one who is flexible, creative, caring, and open-minded, has good active listening skills, is outcome focused, and is able to see and respond to the “big picture” for each patient. Interestingly enough, these are exactly the characteristics of critical thinkers!

Advancing the science of case management takes a high degree of critical thinking, which in turn is dependent upon the more artful aspects of case management. Take some time to reflect on how you can best achieve balance between the art and science of case management in your everyday practice.

Mary Beth Newman, MSN, RN-BC, CMAC, CCP, CCM CMSA President, 2011-2012
The Art and Science of Integrated Case Management

BY DEBORAH GUTTERIDGE, MS, CBIS

The passionate profession of case management is an art and science in and of itself. The “art” of case management can metaphorically be likened to the case manager as an artist, synthesizing a multitude of colors and hues on a large canvas to achieve the desired painting. The patient is represented by the canvas, while the many colors used represent the physicians, nurses, therapists, pharmacists, family, and significant others coordinated by the case manager to paint the perfect picture, or rather, optimal outcome for the health of the patient. The “science” of case management is representative of the skills and attributes possessed by the case manager to achieve successful collaboration of those “colors” toward that perfect painting. The tools of an artist consist of such items as a palette knife, multiple brushes of various sizes and textures, assorted tubes of paint, and a painter’s palette. Case managers are also dependent on a variety of tools in their profession, and one of the most comprehensive and useful tools is that of CMSA’s Integrated Case Management (ICM).

ICM

Today’s case manager is continually honing necessary skills and knowledge base through networking and continued educational experiences, many of which are afforded through both national and chapter level CMSA opportunities. “CMSA’s ICM is a new approach to case management – one with the potential to reduce overall patient-care costs while helping to improve physical and mental health” (Gutteridge, Perez, Kathol, 2011). The most critical component of integrated case management is the development of a mutually respectful relationship and dialogue between case manager and patient.

Regardless of the patient’s health complexities – made up of physical, mental, or substance use disorders, or combination thereof – the case manager is committed to address all barriers to health improvement without cross-disciplinary handoffs. In other words, traditional practice has resulted in the case manager with physical illness expertise handing a patient off to a case manager with more expertise in the mental health arena because the patient has overarching challenges with mental health (such as depression). Integrated case management means that same case manager with physical illness expertise retains the patient’s case; addressing both the physical illness and the role the depression plays as a barrier toward health improvement.

ICM can be used with all populations, ages and demographics, and all acuity levels of health complexity and illness. ICM focuses on the patient as a whole, and assesses his or her biological, psychological, social, and health services domains, and the role each plays as a potential barrier to health improvement. This assessment uses open-ended questions by the case manager to elicit the most comprehensive information from the patient, which can then be ‘scored’ using a color-coded assessment tool, known as the ICM-CAG (Integrated Case Management Complexity Assessment Grid). Scores are derived from objective anchor points, which subsequently drive the development of actionable goals and care plan.

The most critical component of integrated case management is the development of a mutually respectful relationship and dialogue between case manager and patient.

TOOLS INHERENT IN ICM

ICM as a comprehensive skill set can be utilized by case managers in a variety of practice settings. As stated earlier, the successful practice of ICM is directly related to the establishment of a trusting, respectful, open relationship. The ability of case managers to achieve this relationship with their patients is dependent upon the mastery and use of additional tools inherent in the ICM process. These tools include active listening, the use of open-ended questions, and motivational interviewing. The effective use of these skills can lead to a relationship based on mutual respect, trust, genuine caring and concern, empathy, and openness, which will in turn yield an improvement in patient health and outcomes through barrier removal.

ACTIVE LISTENING

Most case managers would consider themselves “active listeners,” however the art of active listening is a skill that is polished through repeated and purposeful use. Active listening is more than merely hearing what the patient says, but being an active participant in the process by being quiet, curious, encouraging, asking open-ended questions, seeking clarification, and to
avoid giving advice or making decisions without first asking permission from the patient (Rollnick, Mason, and Butler, 2003). Making sure the case manager understands what the patient has said, and also means, requires asking for clarification through additional open-ended questions and relating to the patient what they believe they understand them to be saying. The patient perceives the genuine interest and concern, which results in additional open dialogue and further enhancement of the relationship-based approach paramount in ICM.

**OPEN-ENDED INQUIRIES**

The process of ICM and the development of the patient-centered relationship rely on the use of scripted open-ended questions specifically developed to elicit information regarding the patient’s physical health, mental health, substance use, social circumstances, and past and current experiences with the health care community to complete the comprehensive assessment. This information is then used in scoring the ICM Complexity Assessment Grid, which is a prerequisite of actionable goal setting and care plan development.

The art of using open-ended questions requires practice on the part of the case manager, which specifically means avoiding asking the patient questions that can be answered with yes/no responses. An example of an open-ended question a patient is asked in the ICM assessment process includes: “How does your illness affect your ability to do the things you like to do?” (Kathol, Perez, and Cohen, 2010) Rather than answering this question with a simple yes/no response, patients are encouraged to share their feelings of how they see their life being changed and impacted by their illness, requiring them to take an insightful self-assessment of their current station in life.

**MOTIVATIONAL INTERVIEWING**

Motivational interviewing is both an art and science, a critical component to health behavior change. It is best defined as “a client-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller & Rollnick, 1999, p. 25).

As with the process of ICM, motivational interviewing is dependent upon the development of a trusting and respecting mutual rapport with patients, leading to an honest and open dialogue regarding their importance, confidence, and readiness for health behavior change. If patients do not embrace the need for change, believe they have the ability or tools to change, or feel ready to change, the case manager’s attempts to work with them to remove
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The art of using open-ended questions requires practice on the part of the case manager, which specifically means avoiding asking the patient questions that can be answered with yes/no responses.

barriers toward health improvement will be grossly impeded. Motivational interviewing is a process of active and empathic listening, while gently guiding the patient through health behavioral change dialogue. The case manager uses open-ended questions, active and empathic listening, and clarification seeking, reflective dialogue. This is much more than “parroting” what the case manager believes the patient has said. An example of this dialogue follows:

• Patient: “I know I need to stop smoking because I can’t climb the bleachers anymore for my son’s ball games.”
• Case Manager: “It sounds like it means a lot to you to attend your son’s ball games and that you realize smoking may be making it hard to do so?”
• This exchange enables the case manager to elicit further information and explore the patient’s readiness for change, perceived importance to change, and their confidence level to be successful in making that change. The dialogue continues:

  • Patient: “Yes, that’s right. I need to quit but am not sure I can do it.”
  • Case Manager: “What do you think might help or make it easier for you to quit smoking?”
  • Patient: “Well, I am not sure. My wife smokes too, and has no intention of quitting.”
  • Case Manager: “This sounds like it is going to be very challenging for you, but I commend you on your desire and realization of the need to stop smoking. Do you think you might be able to cut your present number of cigarettes in half, rather than trying to stop smoking all together right now?”

The case manager is being supportive and encouraging, while assessing the patient’s confidence and readiness to change his health behavior. This is a prerequisite for establishing goals in care plan development in the ICM process.

This represents only a small introduction into motivational interviewing. Case managers utilizing the art and science of ICM are encouraged to become proficient in the use of motivational interviewing, through training and repeated practice. An excellent resource for self-study is Rollnick, Mason, & Butler’s text “Health Behavior Change: A Guide for Practitioners” 1999.

CONCLUSIONS

In the art and science of case management, passionate case managers continually seek further knowledge and the acquisition of cutting edge tools that can be added to their “case management toolbox.” Just as the painter coordinates the colors on their palette and canvas, the case manager coordinates the stakeholders involved in the patient-centered case management process toward optimal health improvement and outcome. Integrated case management is an effective, proven, and cost saving tool developed to remove barriers and achieve improved health for patients with multimorbidities and health complexity, yet applicable for all patients in all practice settings. Inherent in ICM are the tools of active listening, scripted open-ended questions, and motivational interviewing. According to Rollnick, Miller & Butler, 1999, “You know you’ve got it right when, ‘It feels as if you are holding up a canvas, and the patient is filling it with paint, in places sometimes selected by you, and sometimes by the patient.’”

For further information on CMSA’s Integrated Case Management, visit the CMSA website at www.cmsa.org/icm.

READER RESOURCES

The following sources of information were used to create this article.

About the Author
Deborah Gutteridge, MS, CBIS, is a clinical evaluator/case manager with NeuroRestorative, in Carbondale, Illinois, a company specializing in rehabilitation services for persons with brain or spinal cord injuries. (www.neurorestorative.com)
Evidence-based Practice Is an Art, Not Just a Science
BY HUSSEIN TAHAN, DNSc, RN

Evidence-based practice (EBP) is a highly complex and easily misunderstood term. It is not new to the field of case management; however, it is not intrinsic to it either. EBP refers to making decisions about health care delivery, practice, and care provision to clients in a way that conscientiously and judiciously integrates high quality research evidence with practitioner expertise and the client’s culture, preferences, and values. This sounds rather simple, but in reality it is not. EBP is complex, multi-faceted, and more reflective of a dynamic rather than a unidimensional process.

BACKGROUND
Evidence-based practice requires specific expertise in the evaluation and appraisal of available research evidence; sensitivity, understanding, and acceptance of client’s culture, belief system, and right to choice; and critical assessment of the practice environment (including one’s expertise) to determine how best to apply the evidence into practice and to enhance its impact for the achievement of desirable outcomes for the individual client.

In a previous article published in CMSA Today, Tahan (2011) discussed the science of EBP and its applicability to case management practice. This article focuses on other side of EBP — the art. The art and science parts of EBP are distinct but inter-related; and success in EBP requires addressing both sides equally every time. Effective implementation of EBP for a particular case management intervention requires practitioners to carefully consider both aspects of EBP as they apply to the intervention, the clients to receive such care, and to ultimately effect desirable change (Figure 1).
Evidence-based practice starts with research evidence about a phenomenon of interest but it does not end there. EBP takes into account the research evidence (the science) but also its applicability to and suitability for the individual client (the art). Deciding about the applicability and suitability of the evidence relies on the practitioner’s expertise and judgment (another aspect of the art). EBP informs but never replaces practitioner’s judgment.

The art of EBP may appear soft; however it is as important as the science aspect, if not more critical. From the scientific perspective, the case manager (or case management leader) may use specific tools and methods to locate and appraise available evidence about a phenomenon of interest (e.g., transitional care) and identify its quality and relevance for applicability in practice. The approach, although complex, seems clear and straightforward. The art side of EBP, however, is not as simple as one may think. In contrast with the science, there are no clearly developed rules or nationally recognized tools one may apply in the examination of the art of EBP.

Use of EBP to influence change and achieve effective outcomes is more of a science than art. Use of certain metrics to measure the impact of a newly developed or a modified practice standard (e.g., percentage of clients who were able to quit smoking in a smoke cessation program) is considered an application of EBP as a science. However, the approach and ability to implement the effective change in practice to achieve positive results focuses on EBP as an art. This side of EBP considers the process within and across the intervention (smoking cessation program) and how it is incorporated into one’s practice so that it provides the best context for change at the individual client level, the specific practice setting, and the clinician or professional involved.

When discussing the art of EBP, one must consider two important roles: the role of the clinician or practitioner and the role of the client/support system. The remaining part of this article describes both.
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THE ROLE OF THE CLINICIAN OR PRACTITIONER IN THE ART OF EBP

The art of EBP relies on the clinical knowledge, expertise, judgment, and critical thinking abilities of the practitioner (clinician or leader) engaged in case management practice (Figure 2). It also requires the practitioner to carefully understand and consider the comprehensive needs of clients and their support systems and their impact on practice or care delivery when decisions are made. This is essential for the practitioner to avoid misunderstanding and misapplication of evidence into clients’ care. In addition, effective implementation of EBP in a client’s plan of care is directly related to how well the practitioner is aware of the client’s total situation and is able to incorporate the relevant evidence into the client-centered and holistic case management plan of care.

Figure 2: Examples of Practitioner Factors that Affect the Art of Evidence-Based Practice

- Clinical expertise and knowledge
- Leadership and communication skills
- Critical thinking skills
- Clinical judgment abilities
- Cultural competence and sensitivity
- Understanding and appreciation of the client/support system as an autonomous and independent unit
- Level of comfort in provision of holistic care
- Relationship with the client/support system (e.g., mutual trust and respect)
- Degree of understanding of the practice environment (e.g., case management care setting)
- Competencies in case management and related practices (e.g., ability to develop a plan of care that integrates relevant evidence)
- Open-mindedness and flexibility
- Non-judgmental and non-critical attitude

The art of EBP includes the extent the practitioner considers oneself as a consumer of the evidence and research literature. In this regard, practitioners must regularly evaluate their own practices and outcomes; compare them to the latest and best evidence available at the time of evaluation; and determine how to enhance their practices through the application of the new and relevant evidence. A measure of success the practitioner may apply here is “how skilled” the practitioner becomes in assessing practice, identifying the need for improvement, and exercising the art of changing into the latest evidence-based case management practice. Therefore, the art of EBP from a practitioner’s role relates to the practitioner’s ability to assess and carefully judge the transportability of the research evidence into practice and its likelihood to influence positive change.

Case managers who are astute at EBP understand that the client/support system desires care that is based on the best evidence, yet relevant to the client’s individual situation. They are selective in how they translate evidence into a client’s care. They use necessary critical thinking and clinical judgment skills that allow them to effectively compare the evidence with their past experiences and the client’s situation at hand. Here, case managers do not simply incorporate the latest evidence into practice.

Since available evidence pertains to client populations rather than an individual client, case managers implementing EBP are well aware that research findings will not apply to every individual client and in the same way. Exercising the art of EBP makes a difference here. Case managers rely on their expertise and judgment to determine whether the evidence is suitable to an individual client/support system and if so, how it best applies. They use their critical thinking and clinical judgment skills as flexible tools that allow them to gather necessary information (client and evidence related), identify key interventions, compare and contrast evidence against client’s situation, and evaluate the relevance of these interventions to the case management plan of care of the individual client.

THE ROLE OF CLIENT/SUPPORT SYSTEM IN THE ART OF EBP

Applying EBP to an individual client/support system requires case managers to consider the art side of EBP. Working with clients/support systems consists of understanding their individual behaviors, needs, preferences, values, and interests. Implementing EBP, therefore, must be as much client-centered as it is case management program or intervention-driven. Such approach enhances the application of EBP to meet the care needs of the individual client. Figure 3 offers a list of factors case managers should incorporate in their EBP activities to ensure their approaches are client-sensitive.

Continued on page 27
Author Margaret Moore, MBA, recently presented the topic “Coaching for Sustainable Change” at a grand rounds at Cleveland Clinic in Cleveland, Ohio. The presentation serves as an accompaniment to the following article; to view the full video presentation, click here.

**FACILITATING CHANGE**

When Change Is Hard

The Work of Professional Health & Wellness Coaches

**BY MARGARET MOORE, MBA**

A common lament of my coaching clients when they engage me to re-engineer their lifestyles is that they struggle with an unsolved mystery along the lines of, “I know what I need to do and I don’t get why I don’t do it.” People often spend decades in a stuck stage that I call chronic contemplation in one or more domains in life, whether it’s managing stress and frenzy, getting and staying fit, listening more and talking less in relationships, or losing weight for good.

What I’ve learned from my biggest hero in the science of adult development and coaching, Harvard psychologist Robert Kegan, is that each of us has a worldview, a box of assumptions, beliefs, and perspectives we live in, which constrains our awareness and possibilities. A chronic health and wellness challenge is sending us a message – calling for us to grow into a bigger worldview, getting outside and beyond our boxes. The box could be: “I can lose weight but I regain all of it and more” or “I don’t have time to exercise.” The brain has no roadmap for “I am able to lose weight and keep it off” or “I schedule exercise into my calendar as a priority because I am far more energetic, productive, and creative.”

How do professional coaches or health professionals deploying basic coaching skills help people get beyond their worldviews, outside their boxes to build a new roadmap? When you think about the biology of how the brain learns, you can imagine that people need to build new networks in their brains to support a new and bigger worldview. Now neuroscientists are exploring the biological processes of neuroplasticity, the generation of new neural connections and integrated brain-wide networks that undergird the formation of new habits and the cognitive and emotional mindsets needed to sustain them.

What are the conditions that enable people to create robust neural networks and change for good? Professional coaches are passionate about discovering and enabling these conditions so that they can help their clients make sustainable change in mindset and behavior. Well-trained coaches draw on a rich science-based toolbox for facilitating lasting change. Here’s a sample of how coaches facilitate change.

**MINDFUL ATTENTION**

A calm, warm coaching session enables a client to experience mindful, focused attention on his personal health and well-being. The coaching dynamic enhances self-awareness by quieting a client’s emotional frenzy for a short time, tuning out distractions, eliciting positive emotions about what’s going well, and enabling a curious and engaged inquiry into “what’s really going on here?” Coaching helps clients demystify a complex process of habits of mind and action. The first ah-hahs come from new awareness of patterns of emotions, thoughts, and action, followed by imagining new possibilities. Recently a case manager in a coach-training workshop shared that coaches help patients see windows instead of walls. It’s likely that a calm, mindful space designed to generate self-awareness and new ideas helps new connections to form in the brain.
Facilitating Change

SELF-ACCEPTANCE
Negative emotions narrow the brain’s focus and attention, decrease open-mindedness, and impair creativity, problem-solving, and strategic thinking. Hence, feeling badly about past behaviors and failures restricts the brain’s resources for problem solving and change even before first steps are taken. Creative ideas depend on a good dose of positive emotions lighting up the brain, improving access to memory as well as cognitive agility. A nonjudgmental and empathetic coaching dynamic helps clients let go of the weight of self-judgment and affirm the lessons of the past, so they are more hopeful about proceeding to make changes.

SELF-EFFICACY
“Whether you think you can, or think you can’t, you are right.”
Henry Ford

AUTONOMOUS MOTIVATION
Autonomous motivation (I want to do this because it’s good for me and my future, not because someone else wants me to do it) is the type of motivation that enables sustained weight loss at two years. Autonomy is a core human drive; we are wired to dislike being told what to do. People (all ages) perform best when they are free to make an autonomous choice. This is good news because people also assume personal responsibility for their health when they act autonomously. Unfortunately our health care system, including case management, is designed to be top-down, authority-led, putting the patient in the passenger seat while a healthcare provider sits in the driver’s seat determining the agenda and delivering advice and education, depriving a patient the opportunity to take charge and drill down to find a heartfelt source of motivation.

To support autonomy coaches “get out of sales and get into fishing” by asking open questions without judgmental expectations. Coaches engage in undistracted listening and reflecting with an open, mindful, and curious mindset, rather than preaching and prescribing which shuts down autonomy and often triggers resistance. Clients are taken aback when they connect for the first time with their own heartfelt desire for change – it’s not about pounds on a scale, it’s about unleashing their life force, allowing them to make a bigger impact on their worlds.

Self-efficacy, one’s confidence or belief in one’s ability to be successful, is a co-dependent companion of motivation: both are essential for successful change. The sparkle of motivation fades quickly if confidence in reaching one’s goals falls short. Fortunately there are many roads to building self-efficacy. Coaches help clients identify and deploy strengths and talents, especially those used in other life domains such as work. Often people are renowned for certain skills, for example persistence or reliability in their jobs, and have never considered transferring these skills to their personal well-being. Doing so can lead to breakthroughs, as they tap into existing brain wiring for success.

Barbara Fredrickson, a prominent social psychologist at UNC-Chapel Hill, has unraveled the biology of positive emotions over the past 20 years, and has shown that the main mediator of resilience is the level of positive emotions summoned in a time of stress, setback, or adversity. Surprisingly, the level of negative emotions is not a determining factor; people with high levels of negativity are resilient if they have high levels of positivity. Helping clients amplify sources of positive emotions in their lives not only builds confidence, it’s fun to coach on.

The field of hope psychology has shown that success increases with higher levels of hope, and has focused on what builds hope, which includes setting inspiring goals and identifying multiple pathways to reach them. It’s important to adopt a “scientist” mindset and test or experiment with several options in
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Facilitating Change

How do professional coaches or health professionals deploying basic coaching skills help people get beyond their worldviews, outside their boxes to build a new roadmap?

order to find and settle on one’s unique formula.

While goal-setting researchers have taught us that ambitious goals are more engaging and lead to higher performance than more modest goals, a moderating factor is their impact on confidence. Too-challenging goals can lead to stress and anxiety, damage confidence, and arrest interest in continuation. It’s important to find the right balance of “stretch,” which is engaging and doesn’t jeopardize confidence. There is great power in succeeding at small goals because it builds self-efficacy and keeps motivation fired up as small benefits are savored. When it comes to long-term weight loss, the tortoise is ultimately more successful than the hare. It seems likely that the biological limits of adding new connections in the brain favor a slow and steady pace.

PROCESS OF CHANGING MINDSET AND BEHAVIOR

Now that we have cultivated mindful self-reflection, self-acceptance, and developed self-motivation and self-efficacy, we have the foundation needed for a successful change process. Lasting change depends upon a change of mindset (I love being fit and don’t want to go back to my old sedentary ways) together with behavior change (I consistently do four 30-minute workouts weekly). It takes months of experimenting with goals, practicing, developing skills, gaining insights, bouncing back from setbacks, and recharging motivation and confidence, in order to lay down a lasting brain network that can counter the chaos of everyday life.

Coaching sessions at their best each generate small shifts in mindset as clients adopt new perspectives, question their assumptions, see new possibilities, and find new meanings for their experiences. A surprise question or observation can open a client’s mind and lead to a new insight that likely creates new neuronal connections needed to support lasting change. Harvests of the lessons from goal performance, particularly setbacks and challenges, are rich ground for new insights. There are no “failures” in this process, only opportunities to grow and learn.

Last for now, in the early stages of change, accountability between a client and coach is a key success factor. There are many engaging methods of scheduling and follow-up to choose from – reminders, written progress reports, coaching sessions, phone/email check-ins, and behavioral “apps.”

The best rationale for professional coaches and case managers to get out of the driver’s seat and into the passenger seat is that so long as we are driving, no new connections and networks are forming in the brains of our clients. In fact when we take control of the steering wheel and issue instructions and advice, not only are we depriving people of the autonomy and confidence they need to self-direct their own neuroplasticity, they may even resist our good intentions.

What can you do with your next client or patient to help her to think outside her box, and support her brain to learn and grow?

About the Author
Margaret Moore/Coach Meg, MBA, is the Founder & CEO of Wellcoaches Corporation, a “School of Coaching” for health professionals, and strategic partner of the American College of Sports Medicine. She is Co-Director of the Institute of Coaching, McLean Hospital, an affiliate of Harvard Medical School and co-directs the annual Coaching in Leadership & Healthcare Conference offered by Harvard Medical School. She co-authored the ACSM-endorsed Lippincott, Williams & Wilkins Coaching Psychology Manual, the first coaching textbook in health care and the Harvard Health Book published by Harlequin: Organize Your Mind, Organize Your Life, translating the science of brain organization into self-coaching solutions. This article also draws from the first chapter on coaching in a medical textbook to be published in late 2012, Encyclopedia of Lifestyle Medicine & Health.
Does Discharge Planning Really Begin at Admission?

BY NANCY SKINNER, RN-BC, CCM AND B.K. KIZZIAR, RN-BC, CCM, CLCP

In most acute care facilities, the concept of beginning discharge planning at the time of admission is more of a goal than a process; more an intent than an actuality and more fiction than veracity. Coordination of care as the patient moves through the health care continuum and discharge planning are both significant mandates detailed within the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation as well as essential elements of Joint Commission Accreditation.

CMS states that discharge planning evaluations must be completed in a timely manner so that appropriate arrangements for transitional care can be made prior to discharge. Joint Commission views the effective coordination of transitional services as an essential safety practice and a vital component of necessary acute care services.

Even with this direction and these mandates, all too often the plan to assist the patient in understanding all aspects of the treatment plan and acquiring the skills to execute that plan are provided in a last minute rush to discharge. If hospitals are to advance an enhanced promotion of patient safety across each transition of care and support the patient/family/caregiver and the entire care completion team with the information and tools necessary to reach identified goals, the effective and efficient coordination of transitional services cannot be an afterthought.

Although hospitals are considered the cornerstone of health care delivery, they are also viewed as “islands of excellence” with few bridges to connect that provision of excellent care to the community of providers who are dedicated to serving the patient/family/caregiver in all subsequent environments of care. In today’s environment of health care reform and value-based purchasing, case managers have become the one profession that has accepted the role of bridging the patient from hospital to the next level of care with the necessary tools to succeed in that environment. Case managers have become the linchpins of care; joining patients, their support systems, and their caregivers to all services that are required to promote quality health care services through each transition of care.

While case managers are at the epicenter of transitions of care, the roles and specific functions of case management vary from hospital to hospital with no consistency or agreement regarding job descriptions. Through the years, we have debated the specific responsibilities of the acute care case manager and, to date, we have not achieved consensus. But, we all can agree that effective transitional care is vital to the health of the patient, the financial health of the hospital, and the ultimate viability of the American health care delivery system.

In order to advance effective transitions, it is necessary to work collaboratively to support the development of all necessary steps associated with a transitional process. The following details a timeline for the delivery of transitional interventions that are required to assist hospitalized patients to be successful at the next level of care. The list is neither optional nor solely a function of case management. Each member of the patient-centered team has a role in facilitating completion of these essential functions. The one absolute responsibility of the case manager is confirmation that all components of the transitional process were achieved.

**DAY ONE (DAY OF ADMISSION)**

- Assess transitional options during first interview with the patient/family including a comprehensive assessment of support systems, home situation and previous living environment, ability to care for self, financial and social barriers to care implementation as well as potential clinical needs.
- Establish appropriate level of care. Utilization management is not necessarily a case management function but ensuring that objective criteria has been utilized to determine level of care is a necessary case management role.
- Review the treatment plan to ensure the patient will be provided with the appropriate services without redundancies or unnecessary services.

In order to advance effective transitions, it is necessary to work collaboratively to support the development of all necessary steps associated with a transitional process.
Even with this direction and these mandates, all too often the plan to assist the patient in understanding all aspects of the treatment plan and acquiring the skills to execute that plan are provided in a last minute rush to discharge.

- Collaborate with the treating physician to set an estimated discharge date and disposition. That estimate will be consistently communicated to the entire treatment team, patient, family and caregiver on an ongoing basis throughout the inpatient stay.
- Post the estimated discharge date and objectives on the white board in the patient’s room so the entire team is aware of the planned transition.
- Begin patient education with information regarding diagnosis. All teaching must be provided based on the patient’s cognitive abilities, cultural beliefs and health literacy.
- Provide information to the patient/family regarding transitional options, choices and potential insurance benefits. If the site of discharge is to be other than home, give the family “assignments” early on to visit potential facilities so discharge can be achieved in a timely manner.
- Encourage and facilitate the patient/family’s participation in all treatment decisions and care.
- Collaborate with treatment team to determine discharge recommendations and develop a plan for obtaining necessary services.
- Recognize and respond quickly to any risk factors that might adversely delay an appropriate transition.
- Document all initial transition plan information including discussions with all members of the transitional team including the patient. Documentation usually describes potential discharge options, identified barriers to discharge, patient preferences and available resources.
- Utilize available health information technology to facilitate a sharing of information regarding providers and potential providers of care.
- Establish primary responsibilities for each member of the transitional team.

DAY TWO AND EVERY SUBSEQUENT DAY UNTIL DISCHARGE IS ACHIEVED

- Continue patient/family education including diagnosis, treatment plan and rationale for adhering to that plan.
- Utilize teach back techniques to confirm patient/family understanding of the individualized treatment plan including signs of disease exacerbation and steps to initiate when seeking assistance in managing any increase in disease activity.

- Anticipate barriers to discharge based on past patient admissions and/or experiences.
- Facilitate efficient delivery of health care interventions and positively impact cost of care by avoiding treatments and/or diagnostics that are not directly related to improving the patient outcomes, satisfaction and appropriate transition (i.e. colonoscopy on a patient admitted with pneumonia).
- Amend the proposed transitional plan throughout the entire length of stay as a more effective, or efficient plan is developed.
- Communicate the current transitional plan on a daily basis to the treatment team, treating physician, patient/family and potential community care providers.
- Keep all team members informed of proposed date of transition and alert each to any necessary revisions to that plan.
Case managers have become the linchpins of care; joining patients, their support systems, and their caregivers to all services that are required to promote quality health care services through each transition of care.

- Ensure medication therapy management and medication reconciliation are completed in a timely manner so that patient education and understanding of the medication regime is not rushed.
- Communicate directly with the case manager, care coordinator or clinician who is accepting responsibility for patient at next level of care.
- Arrange any necessary continuing care services well in advance of the day of transition and document confirmation of delivery or anticipated date for the provision of those services.
- Confirm family is aware of day of transition and has made arrangements for transportation and/or completed any other “assignments” they were given.
- Meet with the patient and family (if possible) on the day of transition for closure and final review of transition plan.
- Arrange follow-up contact to measure effectiveness of transitional plan.
- Establish a pathway to review all gaps in transitional planning that may have contributed to a readmission within 30 days.

Some readers may view the above detailed list as too extensive and impossible to achieve within the brief length of stay the majority of patients experience. Other readers may view the list as too limited and not fully representative of all components of the case manager’s primary role and functions. But whichever side of the debate you represent, it is the sincere intent of the authors to develop a pathway for every patient to experience when transitioning from acute care to the next level and site of care. This article and the two previously published articles were developed as the first steps in developing a formal guideline that represents the path for case managers to consider as they assist their patients to navigate the turbulent waters of health care delivery in America. If you have an interest in assisting us in achieving that goal, please contact either author.

Your comments are encouraged and appreciated at casemanager@mac.com or bkandassoc@verizon.net. See Part 1 of this article in CMSA Today Issue 1, 2012 (digital) and Part 2 in CMSA Today Issue 2, 2012.
Make a Difference at CMSA’s 2012 Public Policy Summit

April 23 - 24, 2012

The CMSA Public Policy Summit brings together case management professionals from across the country with the goal of educating Congress on the importance of case management to the effective delivery of health care.

This Summit teaches case managers how to use their local grassroots networks for legislative success and is also a one-of-a-kind opportunity to network with CMSA’s Public Policy leaders from all over the US.

The event is open to all CMSA members, staff, volunteers, and case management professionals who are passionate about association issues and want to make a difference by meeting and networking with fellow advocates. Won’t you join our efforts on the Hill?

Experience these exciting Washington, DC, events:
- Welcoming Reception
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- Leadership Meetings
- Breakout sessions
- Congressional visit
debrief & receptions!

Confirm Your Spot at CMSA’s 2012 Public Policy Summit Today!
Register online at www.cmsa.org/PolicyMaker
Living in a state steeped in history, we fervently believe our time for advocating for multi state licensure (MSL) in Massachusetts is NOW! Our long-term grassroots efforts are beginning to take hold. The Case Management Society of New England (CMSNE) Public Policy Committee members presented testimony to the Joint Committee on Public Health on September 20, 2011, in support of MSL. We were the first called to the table in a day-long hearing of multiple state nursing initiatives before this committee in a standing-room-only auditorium. There was absolute quiet and attention given to our every word. Some legislators were unaware of the role of case managers, until we gave examples of our practice. Telemonitoring and communication were discussed and we explained nurses may be unaware in which state our patients/clients are located at the time of a call. We gave examples of many patients going to recuperate with family members that live out of state. Even if we call the patient’s cellular phone with our local area code, we could be giving nursing advice across state lines. Our state borders Rhode Island, New Hampshire, and Maine, all of which are members of the NLC.

Our efforts resulted in numerous questions from many committee members. We reminded them how many varying New England state residents, international visitors, and our military wounded warriors seek health care in Massachusetts, due to the many specialty services available here. We always care for each person in the same manner, but when taking calls from families, we risk practicing across state lines without a license.

At the end of the day-long hearing, we were approached by members of the committee and the legislator who filed HB1493, who asked us to form a Task Force to discuss this bill further to assist them with their decision-making process.

We are encouraging all members of CMSA to visit our Chapter website, www.CMSNE.org, and go to Public Policy Initiatives to register your support.

Our testimony, to increase nursing awareness, was also reported in a December 2011 newsletter distributed to all nurses in the state of MA.

We have had multiple Task Force meetings. Our most recent meeting was an hour session with the House Chairman of the Committee. Members in attendance included representatives from the MA Hospital Association (MHA), the Organization of Nurse Leaders from MA and RI (ONL; formerly the MA Organization of Nursing Executives), CMSNE representatives and lobbyists. Additionally, we have received the support of the MA Board of Registration in Nursing (BORN), who have been kept apprised of all our endeavors and the MA Occupational Health Nurses (OHN), whose 1,000 person-membership is partnering with us.

The MA Registered Nurses (MARN, the MA affiliate of ANA) sponsored a Lobby Day at the State House in March 2012 and asked us to be the keynote speakers. Additionally, we plan to reach every nursing organization in Massachusetts to educate and include them in our quest.

Our goal is to continue our grassroots efforts by having our members send emails to their legislators and to the Committee. We are encouraging all members of CMSA to visit our Chapter website, www.CMSNE.org, and go to Public Policy Initiatives to register your support. This would be especially important if you belong to a Compact State to let them know how it works for you. Be sure to include your name, home/email addresses and phone number to be heard.

If we continue to educate and motivate nurses to join our “Revolution for a Resolution to Obtain MSL,” our hope is we can all practice without fear of litigation, ensuring not only the safety of all our patients/clients, but the nurses that give their care.
# CMSA CORPORATE PARTNERS

The contribution and continued support of the following companies are much appreciated. CMSA thanks these companies for their continuing support of the association and the case management profession. CMSA’s Corporate Partner Program offers interrelated education discounts, membership discounts, exclusive national visibility, and much more. For more information, visit www.cmsa.org/partners or call Lindsay Harp at (501) 673-1117.

**CMSA CORPORATE PARTNERS AS OF 3-15-12**

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- Advantage Nursing Services
- Aerotek
- Albert Einstein Healthcare Network
- American Sentinel University
- Arcadia Health Care
- Avedon Health Systems
- Biogen Idec
- Bosch Healthcare
- Continuity Care Home Nurses (CCHN) Inc.
- CSL Behring L.L.C.
- EBI, LLC / dba Biomet Spine & Bone Healing Technologies
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- Sterling Case Management Solutions
- TCS Healthcare Technologies
- The SCOOTER Store and Alliance Seating and Mobility
- The Standing Company
- Total Living Choices
- University of Southern California
As you may know, CMSA partnered with Sanofi US to found the National Transitions of Care Coalition (NTOCC) in 2006. Since that time, NTOCC has made tremendous strides increasing awareness about the consequences caused by poor transitions in our health care system. The Coalition has also developed numerous tools and resources to help all health care professionals, patients and their caregivers in ensuring better, safer and more efficient transitions.

CMSA helped launch NTOCC because as case managers, we see every day the breakdowns in communication that result in poor transitions, endangering our patient’s lives and driving up costs. We also know that case managers are uniquely positioned within the health care system to create better transitions and increase awareness not only among patients and caregivers, but also among other health care professionals.

We didn’t accomplish this much with CMSA alone: NTOCC has partnered with over 30 industry leading professional associations, medical societies, patient and caregiver groups, standards and quality bodies, and government agencies who have served on NTOCC’s Advisory Task Force. Not only has this broader engagement enabled success for NTOCC’s mission, it has dramatically increased the prestige of case management among our medical peers and highlighted to policy makers and industry leaders the need to invest in effective case management to improve patient safety, increase quality and control costs.

NTOCC has become so successful – but the need is still so great – that last year CMSA, along with Sanofi US and the other organizations in the Advisory Task Force, voted to establish the National Transitions of Care Coalition as an independent organization. We are pleased to announce that as of January 2012, NTOCC has incorporated as a 501(c)(4) association with an independent Board of Directors. The establishment of an independent NTOCC will allow the coalition to bring in more partners and supporters, allowing for the creation of even more effective and robust solutions and tools. These resources will be made available to the health care community that will continue to help case managers improve the quality of care for transitioning patients. CMSA will retain a seat on the new NTOCC Board and we will remain actively engaged in the Advisors Council (the reconstituted Advisory Task Force). We will continue to support the use of NTOCC resources by our members and ensure that CMSA members are made aware of new resources as they are developed. Finally, by championing improvements in transitions of care we will continue to see NTOCC raising the visibility of case management and case managers.

We want to thank all of you for your hard work in moving this issue from one on the periphery of health care to one of central prominence in health care reform. We specifically want to thank our representatives on the NTOCC Advisors Council – Connie Commander, Margaret Leonard and Nancy Skinner – who have done such a fantastic job of representing CMSA and case managers and will continue to ensure effective connections between NTOCC and our CMSA community. We also wish to thank the Presidents who have supported this important initiative and helped us develop NTOCC to this point: Connie Commander, Peter Moran, Jeff Frater, Margaret Leonard and Teri Treiger.

Please visit www.ntocc.org to learn more about the new developments occurring at NTOCC. Sign up as an individual subscriber to receive updates and information directly from NTOCC. Encourage your companies and organizations to support NTOCC's mission by joining as an Associate Member and implementing NTOCC solutions.

Thank you all for your dedication and hard work.

NEW KNOWLEDGE CENTER

CMSA Transitions to Improved Learning Management Platform

In March 2012, CMSA launched the first element of its new Knowledge Center, the improved and user-friendly Educational Resource Library. The ERL is a web-based, dedicated learning platform for case managers and employers looking to provide educational resources to their employees. This platform is available to the entire case management community, providing over 120 Continuing Education courses and CE Credits from the Commission for Case Manager Certification and the California Board of Nursing. Convenient, web-accessible courses and various career resources make the ERL a valuable online destination for health care professionals.

This summer, the Knowledge Center will integrate CMSA's Extended Conference, a program which offers CE coursework and lectures based on material presented at CMSA's Annual Conference & Expo. Head to www.cmsa.org/education to access the ERL.

Additional innovative and interactive features are in the works for CMSA's Knowledge Center; stay tuned in the coming months for announcements regarding these exciting changes!
LAST CALL FOR CMSA’S SPRING MGAM CAMPAIGN

Contest Ends April 30, 2012

Spread the word...CMSA is “THE PLACE” for the content, community, and collaboration case managers crave! And to help your association be all it can be, we must continue to attract new members! That’s just what the Case Management Society of New England has been doing. The chapter recently recruited 14 new members during their conference and CCM prep course held in March.

We know the best tool to do so is WORD OF MOUTH – so please join the challenge to help get the word out to prospective members about all that CMSA offers!

CMSA is the leading source for the case management industry, and recruiting is an excellent opportunity to share your enthusiasm and excitement for your organization with non-members.

Because today’s technology makes communicating with your friends, coworkers, colleagues, and other potential members easier than ever before, perhaps you’d prefer to reach out to potential members via text message, e-mail, blog, Facebook, Twitter, LinkedIn, or YouTube.

However you choose to invite others, don’t forget to emphasize the value and benefits of joining a professional organization like CMSA, including:

• $100 OFF CMSA’s Annual Conference & Expo registration fee
• Career advancement through customized educational programming
• Products and services tailored to meet the changing needs of the case management industry
• Networking opportunities with intelligent, like-minded professionals who are immersed in the inner workings of their industry, providing participants with access to a variety of opinions and ideas
• And much more!

Visit CMSA’s website to find out more about how you can be a great CMSA recruiter!

22ND ANNUAL CONFERENCE & EXPO

• Trivia Quiz Winners
  Congratulations to Bonnie Robb, Lolita Bell and Donna Fox, winners of the San Francisco Trivia Quiz! All participants win a free conference registration to the 2012 Annual Conference & Expo.

• Register for San Francisco 2012 by May 31 and Save
  Groups of 3 or more people, registering together, receive an additional $100 off per person.

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CASE MANAGEMENT WEEK 2012

The winner of the National Case Management Week 2012 Slogan Contest is Terry Wooding, BSN, RN, CCM. Terry is a member of the CMSA NC Piedmont Triad Chapter who submitted the winning slogan: “Case Management: Engaging, Educating, Empowering – Excellence in Action.”

This year’s graphic reflects the chosen theme with a design inspired by an award medallion of gold and purple, colors traditionally associated with royalty and power.

Please join CMSA in congratulating Terry! Thanks go out to everyone who participated in the contest and sent in a CM Week slogan idea. Please keep them coming next year. We have some creative case managers out there. To see all 2012 CM Week Entries, visit the CM Week Facebook page at www.facebook.com/NCMWeek.

Plus, check out all the winning products that CMSA will be offering for National CM Week 2012. They’ll soon be available for purchase at www.cmsa.org/cmweek and onsite at the Annual Conference in San Francisco.

VISIT CMF BOOTH, BE PART OF INDUSTRY’S FUTURE

Through its network of generous donors, the Case Management Foundation helps to develop innovative projects and programs that contribute to the case management field and the people it serves. Attending CMSA’s Annual Conference? Don’t forget to stop by the CMF booth for more information about projects, programs, and to find out how YOU can become a part of the future of case management!
ALL MEMBER CALL UPDATE

On February 16, CMSA President Mary Beth Newman MSN, RN-BC, CMAC, CCP, CCM addressed the CMSA community regarding current Association activities and member benefit updates. If you missed this call or simply want to hear it again, you can listen to the full call recording here. The next All Member Call is coming up on May 16, 2012 at Noon CDT; register to stay connected to your organization and to understand how your organization is supporting you! Reserve your webinar seat now by clicking here.

Special Offer for Nonmembers: Join this call to hear an exclusive membership offer and to learn more about CMSA!

2012 PUBLIC POLICY SUMMIT IS IN APRIL

The 2012 Public Policy Summit takes place April 23 - 24 on Capitol Hill. Attendees will enjoy what is sure to be an exhilarating D.C. experience, which includes discussion of CMSA Public Policy initiatives, a Congressional staff guest speaker, Congressional appointments, tourist activities, and more.

Continued from page 13

Figure 3: Examples of Client/Support System Factors that Affect the Art of Evidence-Based Practice

- Culture, values, rituals and belief system
- Needs, interests and preferences
- Abilities and skills relevant to care requirements
- Preferred activities and level of participation in care and decision making
- Socioeconomic status and resources available
- Psychosocial status including availability of social network or support system
- Feasibility of active involvement in care
- Knowledge and understanding of health condition and care regimen
- Opinions about care options and case management plan of care

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Needs of clients/support systems, care delivery processes, and practice settings are never static. Additionally, care processes for an individual client are never linear; they are rather iterative and multidimensional. Therefore, EBP is never a one-time deal. Goals and interventions are constantly modified or adapted; new ones are chosen; each of them must be responsive to a client’s need and/or preference especially as the goals change over the span of the interventions and the case management plan of care. The art of EBP then is the ability of the practitioner to deconstruct the evidence based on the client needs and apply interventions based on the extent the evidence supports the applicability of the intervention to the unique characteristics of the client’s situation.

Another application of EBP into case management practice as an art as opposed to science is the approach the case manager takes to facilitate a client’s decision to implement a particular intervention the client may not have perceived as necessary or important. In this case, the case manager summarizes to the client available evidence about the intervention and how it has resulted in positive outcomes. Here, the case manager uses the evidence to increase the client’s awareness about the particular situation, facilitate informed decision-making, and potentially arrive at a plan of care that incorporates the desired intervention.

In the above example, the case manager avoids forcing the issue on the client. Rather, he/she advocates for an evidence-based intervention without compromising the client’s integrity, right to choice or autonomy. The case manager connects EBP to the client’s experiences and situation, expresses understanding of the client’s reluctance or enthusiasm toward the recommended intervention, and willingly responds to the client’s inquiries to ultimately effect positive change.

CONCLUSION

The application of both forms of EBP (as an art and a science) in case management is essential for decreasing uncertainty about how to achieve positive outcomes for the client/support system and the case management practice setting. If case managers or their leaders incorporate the best evidence into practice while neglecting clients’ values and preferences and practitioners’ knowledge, expertise, and critical judgment they are doomed to fail or achieve limited outcomes in the least. As a rule of thumb, success in EBP must always include careful consideration for both the art and science of practice.

READER RESOURCES


About the Author

Hussein Tahan, DNSc, RN is an independent consultant in hospital design, management, and operations. He is a case management expert and researcher and an advisory board member of CMSA Today and Professional Case Management journal. Hussein is the co-author of CMSA’s Core Curriculum for Case Management and Case Management: A Guide for Education and Practice. He can be reached at htahan@verizon.net.
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