CE 1.5 ANCC Contact Hours

Professional Case Management
Vol. 25, No. 2, 56-76
Copyright © 2020 Wolters Kluwer Health, Inc. All rights reserved.

Shared Decision-Making

A New Frontier for Case Management Leadership

Teresa M. Treiger, MA, RN-BC, CCM, FABQAURP

ABSTRACT

Purpose/Objectives: Despite improved access to information, many people are neither engaged in their health care nor in the decision-making process. As the hub of care coordination, case managers are perfectly positioned to participate in and support shared decision-making (SDM) efforts. This article addresses SDM from a case management perspective.

The objectives are to

- define SDM and its process;
- discuss the ethical mandate of SDM;
- present an SDM approach;
- identify support for SDM within case management foundational documents;
- associate SDM to case management communication and relationship skills; and
- present an informed consent to case management scenario using a modified process recording.

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

Findings/Conclusions: Communication skill is an essential case management competency. Shared decision-making is a communication process in which a case manager and a client collaborate to make the best health care decisions based on what matters most to the client. Case managers must undertake education and training to become fluent in shared decision-making as a core feature of person-centered, professional practice.

Implications for Professional Case Management Practice: Professional case managers must understand the concept and principles of shared decision-making as applies in their practice as well as their responsibilities to support care team colleagues using shared decision-making concepts. Organizations should incorporate shared decision-making language in program descriptions, individual performance plans, satisfaction surveys, and department/organization goals.

Key words: *case management, communication, competence, person-centered care, relationship building, shared decision-making.*

In 2018, a Medicare coverage policy required providers (physician or a designated nonphysician practitioner) to participate in shared decision-making (SDM) with a patient before undergoing an implantable cardioverter-defibrillators procedure (Jensen et al., 2018). Shared decision-making is also required prior to consent for some lung cancer screenings and prophylactic left atrial appendage closures. Mandated SDM is expected to expand into other preference-sensitive procedures and eventually become the de facto model for patient engagement and health-related communication.

Shared decision-making is not a new communication model. It has been recognized and discussed in literature for decades. Going back to 1972, Veatch presented the evolution of health care from privilege to fundamental right within the context of four ethical relationship models: Engineering, Priestly, Collegial, and Contractual. It is within the Contractual Model that a patient–provider relationship allowed for sharing of ethical authority and responsibility. Expectations of veracity, autonomy, beneficence, nonmaleficence, and justice are present in this model (see Figure 1).

The Contractual Model identifies patient control of decision making but does not require the patient be involved in every incremental decision of the care process. In his word, "the myriads of minute medical decisions which must be made day in and day out in the care of the patient will be made by the physician

Address correspondence to Teresa M. Treiger, MA, RN-BC, CCM, FABQAURP, Ascent Care Management, Quincy, MA 02171 (teri.treiger@comcast.net).

The author reports no conflicts of interest.

DOI: 10.1097/NCM.0000000000000394

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

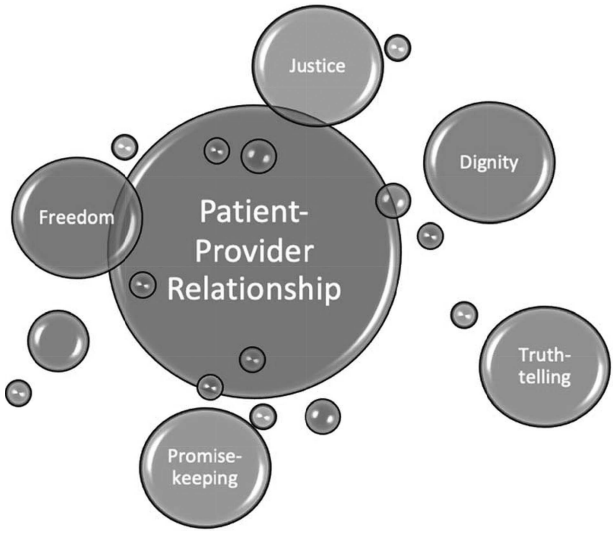

FIGURE 1
The contractual model of patient–provider relationship. From Veatch (1972).

within that frame of reference" (Veatch, 1972). "That frame of reference" being patient preference. The reason this works is because incremental decisions are predicated on a trust-based relationship between the patient and the provider. The patient trusts that the provider makes independent decisions taking his or her preferences into account. If trust is broken, so too is the contract (Veatch, 1972).

In the seminal book, *Crossing the Quality Chasm: A New Healthcare System for the 21st Century* (Institutes of Medicine [IOM], 2001), an overall system redesign identifies the patient as the locus of control. The IOM, now known as the National Academy of Medicine, further explained that the patient should have the "necessary information and the opportunity to exercise the degree of control they choose over health care decisions" (p. 61). The authors included SDM in describing the Aim of Effectiveness, one of the Six Aims of a new health care system:

> health care organizations and professionals could do a far better job than they do today in determining the most appropriate therapies on the basis of the strength of the scientific evidence; the stakes involved; clinical judgment; and, especially where the evidence is equivocal, shared patient and clinician decision making. (p. 48)

Shared decision-making provides professional case management with the opportunity to demonstrate its value to health care in care coordination, communication, relationship building, and leadership excellence. As a key stakeholder in care coordination, professional case managers are positioned to participate in SDM as it relates to the case management engagement and in support of care team colleague efforts. This article focuses on SDM from case management's perspective.

Case Management Embraces SDM

If the incidence of a word is an indicator of its importance to the content being communicated, the number of times the term "relationship" is mentioned throughout case management codes and standards is a clue as to the prominence it has in practice. Examples include the following:

- Sixteen times in the National Association of Social Workers (NASW) Standards for Social Work Case Management (2013).
- Twelve times in the Case Management Society of America's (CMSA's) standards (2016),
- Nine times in the Commission for Case Manager Certification's (CCMC) Code of Professional Conduct (2015), and
- Two instances in the American Case Management Association (ACMA) standards (2013).

How are case managers positioned to take a lead role in SDM? To assess this, one must look to philosophy, principles, practice standards, and codes of conduct of professional societies and certification bodies. The CMSA and the CCMC are featured in this article because both are agnostic as to a case manager's educational background and population served and are applicable across all practice settings.

In its standards, the CMSA posits that relationships are integral to effective interprofessional practice (2016, p. 6) and that successful care outcomes are predicated on case manager's expertise, specialized skills, knowledge, and competencies applied throughout the engagement, including positive relationship building and effective communication (2016, p. 15). The CCMC's Code of Professional Conduct defines expectations that a board-certified case manager provides necessary information to educate and empower a client in making informed decisions (2015, p. 8). The CCMC (2015) recognizes that case management services are optimized in a climate allowing direct communication between the case manager and the client and across the health care team.

Incorporating SDM into the bedrock of case management practice is essential, given its ethical footing and potential to positively impact provider–client interactions, quality, and safety (Agency for Healthcare Research and Quality [AHRQ], 2016; National Quality Partners [NQP], 2018). Adherence to SDM principles is voluntary, similar to case management standards of practice. Case managers should adhere to applicable practice standards but these are generally not mandated by law or regulation. To further

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

As a care coordination leader, a case manager continuously hones her or his communication techniques over the span of a career. Competency with both verbal and nonverbal communication skills is essential in the development trajectory of a professional case manager.

clarify this distinction, the following are examples of voluntary versus required practice expectations:

- A case manager holding a license *must* adhere to the laws and regulations that govern said licensure.
- A case manager *should* embrace practice standards as a baseline of practice.
- A case manager *must* abide by the policies and procedures of his or her employer with the exception of those that violate the scope of his or her licensure.
- A case manager *must* maintain current clinical knowledge and remain informed of practice developments to qualify for ongoing licensure or certification.
- Case management departments *should* support their licensed employees in the acquisition of new and ongoing skills and knowledge to improve service delivery to their population.
- A board-certified case manager *must* adhere to the granting authority's code of conduct (and other requirements) to maintain certification.

The SDM ship is in port and it presents another opportunity for case managers to undertake a collaborative approach in all client and colleague communication.

Communication Competency

By definition, case management leverages communication as a tool to conducting effective practice. Case management is defined as:

> a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. (CCMC, 2019a)

As a care coordination leader, a case manager continuously hones his or her communication techniques over the span of a career. Competency with both verbal and nonverbal communication skills is essential in the development trajectory of a professional case manager (Treiger & Fink-Samnick, 2016). It is a feature of case management's philosophy and guiding principles, "Successful care outcomes cannot be achieved without the specialized skills, knowledge, and competencies professional case managers apply throughout the case management process. These include, but are not limited to, motivational interviewing and positive relationship-building; effective written and verbal communication" (CMSA, 2016, p. 12). An underlying value for board-certified case managers is the belief that "case management is a means for improving client health, wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation" (CCMC, 2015, p. 4).

From the point of first contact, the relationship with a client is dependent upon clear and consistent communication. A functional client–case manager relationship is built on a foundation of mutual trust, respect, honesty, compassion, empathy, transparency, and ongoing communication (CCMC, 2019b). Each interaction is essential to maintain and enhance this relationship. It is through communication that a case manager encourages the client to move toward improved health outcomes and self-management ability. Failing to establish a trust-based relationship of open communication, transparency, and cooperation inevitably brings on subsequent problems, including but not limited to nonadherence (CCMC, 2019b, 2019c).

Communication is a long-standing case management skill. This has been recognized as far back as the days of Mary Richmond (1861–1928). In the Proceedings of the National Conference of Charities and Correction, Richmond specifically mentions the lack of coordination and communication. In what was a case management model of fraud detection, Richmond (1901) discussed that during visits to community service recipients, more could be accomplished

From the point of first contact, the relationship with a client is dependent upon clear and consistent communication. A functional client–case manager relationship is built on a foundation of mutual trust, respect, honesty, compassion, empathy, transparency, and ongoing communication.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

using a care coordination model of friendly visits in which the focus was shifted to identification, understanding, and addressing the challenges.

It is fair to say that both communication and relationship building are in the bedrock of professional case management practice. This presents as if case managers should already be experts in these realms. However, this is an unfair characterization because of the evolving nature of competence across case management ranks. Competency models recognize necessary skills and the distinction between levels of expertise. COLLABORATE addresses professional communication as a key concept in the leadership competency (Treiger & Fink-Samnick, 2016). The CMSA (2014) .e4 map acknowledges communication and its distinctions across six levels of expertise.

The benefits of standardization in case management doctrine are numerous, including the development of unified professional knowledge, skills, and graduated competencies. However, one must recognize that not all individuals working under the case manager job title are working in a professional capacity. In addition, case managers lack job title protection, a universally agreed-upon definition, and a set of overarching practice standards. These inconsistencies present challenges to practitioners as well as to employers, accreditors, and regulators in laying a basic foundation of required education, training, and competency-driven professional practice.

Elements and Definitions

In recent years, SDM received renewed examination, investigation, and conceptual expansion in a variety of practice areas (Daly, Bunn, & Goodman, 2018; de Mik, Stubenrouch, Balm, & Ubbink, 2018; Friedberg, Van Busum, Wexler, Bowen, & Schneider, 2013; Gionfriddo et al., 2013). Although SDM research applicability to case management is limited, the argument as the ethically correct thing to do favors widespread adoption across care settings.

Makoul and Clayman's (2006) systematic review identified nine essential elements that are key to the SDM construct. These elements, common across the published models at the time, are as follows:

- Define/explain problem
- Present options
- Discuss pros/cons (benefits/risks/costs)
- Patient values/preferences
- Discuss patient ability/self-efficacy
- Doctor knowledge/recommendations
- Check/clarify understanding
- Make or explicitly defer decision
- Arrange follow-up

Acknowledging the lack of a core SDM definition, Makoul and Clayman (2006) identified ideal elements and general qualities. These considerations should be reflected in any SDM framework. Ideal elements include unbiased information, defined roles (desire for involvement), supportive evidence, and mutual agreement. General qualities include the following: deliberation/negotiation, flexibility/individualized approach, information exchange, involves at least two people, middle ground, mutual respect, partnership, patient education, patient participation, and process/stages.

Although variation of SDM definition still exists, two current motifs were introduced by the AHRQ and the NQP.

Agency for Healthcare Research and Quality defines SDM as "a model of patient-centered care that enables and encourages people to play a role in the medical decisions that affect their health. Shared decision-making occurs when a health care provider and a patient work together to make a health care decision that is best for the patient. The optimal decision takes into account evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences" (AHRQ, 2016) operating under two premises:

- First, consumers armed with good information can and will participate in the medical decision making process by asking informed questions and expressing personal values and opinions about their condition(s) and treatment options.
- Second, clinicians respect patients' goals and preferences and use them to guide recommendations and treatments. (AHRQ, 2014)

National Quality Partners put forth the following definition expanding beyond medical decision

Agency for Healthcare Research and Quality defines SDM as "a model of patient-centered care that enables and encourages people to play a role in the medical decisions that affect their health. Shared decision-making occurs when a healthcare provider and a patient work together to make a healthcare decision that is best for the patient. The optimal decision takes into account evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences."

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

making to be inclusive of other professional care team members. The definition is "a process of communication in which clinicians and patients work together to make optimal health care decisions that align with what matters most to patients" (NQP, 2018, p. 3). National Quality Partners continues with the following definition components:

- clear, accurate, and unbiased medical evidence about reasonable alternatives—including no medical intervention—and the risks and benefits of each;
- clinician expertise in communicating and tailoring that evidence for individual patients; and
- patient values, goals, informed preferences, and concerns that may include treatment burdens.

Shared decision-making is a compelling communication model despite recognized issues that raise cautionary flags as to effectively launching it into everyday practice. Among the barriers are a patient's reticence to ask questions of his or her provider(s), health care condition and system information imbalance, lack of provider knowledge and resources, lack of engagement (or interest) on the patient's part, provider misunderstanding of patient intent, and lack of professional education and training (AHRQ, 2014; NQP, 2018). A closer look at the SHARE SDM process steps sheds further light upon undertaking case management practice standardization.

SDM Process

Conducting SDM is best undertaken according to a defined process. A variety of models have been considered and/or implemented in different practice settings and specialties (Boland et al., 2019; Braddock, Edwards, Hasenburg, Laidley, & Levinson, 1999; Daly et al., 2018; Friedberg et al., 2013). For the purpose of this article, AHRQ's SHARE model is presented (see Figure 2). SHARE is a five-step process that addresses the exploration and comparison of the benefits, harms, and risks of health care options accomplished through meaningful dialogue. Ultimately, this model respects what matters most to the client.

The process steps of SHARE are as follows:

- **S**eek your patient's participation
- **H**elp your patient explore and compare treatment options
- **A**ssess your patient's values and preferences
- **R**each a decision with your patient
- **E**valuate your patient's decision. (AHRQ, 2014)

Step 1: Seek your patient's participation: Achieving SDM success builds from the premise that a functional provider/client relationship exists. The client

FIGURE 2
The SHARE model. From Agency for Healthcare Research and Quality (2016).

trusts that a case manager has the knowledge, experience, and resources to assess and address a biopsychosocialsystem health-related concern as well as the ability to present unbiased information and options in an open and honest dialogue. The case manager expects that a client is truthful within the sanctity of their relationship. Both case manager and client share and respond to information, evidence presented, and questions asked and answered, and consideration is given to alternative approaches. Without an existing functional relationship, the dynamic between client and health care professional may serve as a barrier to a productive case management engagement and SDM as an important aspect thereof.

A case manager undertakes numerous tasks as part of the case management process. For the distinct process phases, as identified by CCMC and CMSA, refer to Figure 3. Although care coordination professionals understand this process, it is not readily known to or accepted by laypeople, consumers, and/or those outside of case management. Hence, it is essential to explain this process to each client in layperson-friendly terms as a foundational building block of a trust-based relationship. Without this precedent understanding, client, caregiver, and fellow care team members may not understand the detailed work and level of effort on which a case management plan of care is developed and executed. Ways in which to make the case management process more relatable include the following:

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

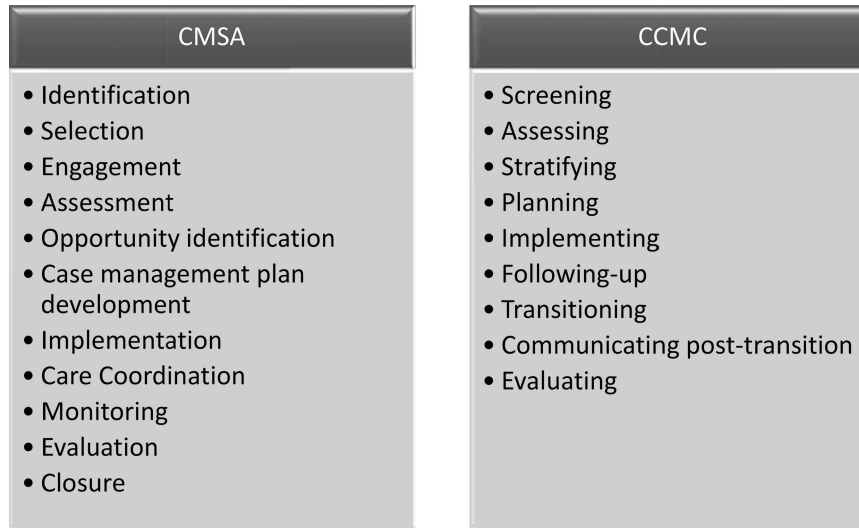

FIGURE 3
Iterative case management process activities. CCMC = Commission for Case Manager Certification; CMSA = Case Management Society of America. From the Commission for Case Manager Certification's Case Management Body of Knowledge (2019d) and the Case Management Society of America's Standards of Practice (2016).

- Use of real-life scenarios to illustrate a point.
- Explain it in information stages rather than the entire process in one encounter.
- Use examples of decisions that take place in the case management process.
- Highlight the value of case by describing how you intervened in situation and the positive outcome your action had on the client.
- Provide figures and/or documents to illustrate your description(s).
- Pause to invite questions throughout your dialogue.
- Frequently ask probing questions to determine understanding.

In addition to understanding the work process, be sure to highlight critical issues, such as time sensitivity, which affect the acuity of decision making. Be clear that decisions made during the case management engagement are the client's choice within the constraints of law, regulation, health plan policies, and client safety.

When starting an SDM dialogue, agree upon the key participants in the process. Although these may change, it is best to establish a mutual understanding from the outset. Decision making may take place between you and the client or may involve other members of the care team. Whatever the situation, ensure that the client understands who is to be involved as this helps avoid confusion and/or surprises that may derail the entire process. Of course, unanticipated events happen every day. These strategies may not eliminate risk, but they will help mitigate reasonably foreseeable adverse events.

There are sure to be situations in which a client expresses reticence to engage as the decision maker. Seek to understand the reasons why a client hesitates. Investigate cultural and/or linguistic forces influencing the client's behavior. Employ motivational interviewing technique as a means to address ambivalence and insecurity (see Figure 4). Ultimately, respect the client's wishes and incorporate them into case management plan of care.

It may be appropriate to conduct SDM conversations with designated caregiver. If that is the case, SDM steps guide the communication process for as long as the designated point of contact is willing to participate. Despite an initial hesitation to engage in SDM, include the client in decision making whenever possible (AHRQ, 2014). Ultimately, the decision to not engage in SDM is a client/caregiver option. Unless case management is formally declined, continue to educate and advocate on behalf of your client. As in all things, document your interactions and decision-making efforts thoroughly.

Keys to this step are as follows:

- Clarify the specific decision point(s).
- Ask for client/caregiver participation in the decision-making process.
- Emphasize decision making as a client prerogative.

Step 2: Help your patient explore and compare treatment options: Whether it be a case management–specific decision or a case manager in a supportive role as a care team member, this step requires purposeful, unbiased dialogue. It calls on communication competency for ascertaining a client's current level of knowledge about his or her health condition and available options as to the decision point.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

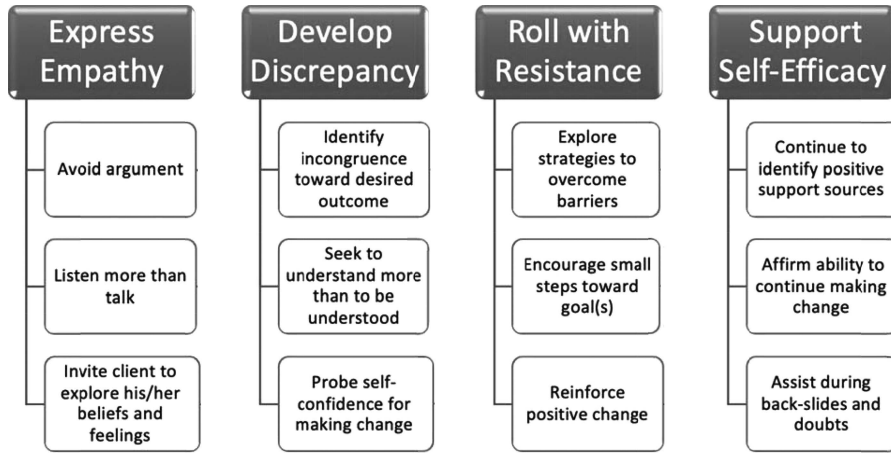

FIGURE 4
Motivational interviewing. From SAMSA-HRSA Center for Integrated Health Solutions (n. d.) and Tomlin, Walker, Grover, Arquette, and Stewart (2005).

In today's world, information is freely available via the Internet; however, not all sources of information are reliable. Educating clients regarding how to identify a reliable website(s) becomes a priority for SDM dialogue. As appropriate, review layperson-friendly literature and websites. Provide hardcopy handouts if connectivity is inconsistent or when it is a client's preference. There may be constraints (e.g., organizational policy) as to approved information sources for use with clients. If your organization does not maintain an approved list of Internet sources or a policy relating to website referrals, review new resources with a supervisor or medical director for an additional layer of evaluation prior to distribution.

When providing guidance on Internet searches, avoid summarily dismissing client-found Websites. Instead, evaluate them to decide on their strengths, weaknesses, and bias. Make sure to applaud the effort. In the process of the discussion, speak to reliability of Internet information and continue to build your client's confidence by sharing ways to be more discerning of the information discovered on websites. Educate your client to look for a Health on the Net (HON) icon. The HON is a nonprofit organization promoting transparent and reliable health information online. The HON seal of approval means that a website has undergone an evaluation following HON's principles of Authority, Complementarily, Privacy policy, Attribution and date, Justifiability, Transparency, Financial disclosure, and Advertising policy (HON, n. d.; Sewell, 2019). These principles are expanded in Figure 5.

Discussing a client's available options may include referencing statistics and/or comparative effectiveness information. When discussing numbers, take special care to ensure that the client understands what the numbers signify. If you reference a statistic, be clear as to what it means. Seek additional support if unsure as to how best to present numeric information. Where rating systems are concerned, refer to reliable, unbiased sites, such as Home Health Compare versus sources that improve an agency's listing based on advertising revenue. For example, if a client is considering home health care agencies, present the quality of patient care and patient satisfaction survey ratings of each in absolutes rather than as Agency A being rated "twice as high" as Agency B (NQP, 2018).

Keys to this step are as follows:

- Set the stage by describing the decision-making process.
- Remain unbiased when presenting information.
- Avoid dismissing a client suggestion without a due diligence evaluation.
- Let the client know that you will return after researching a new alternative.
- Thank the client for engaging in the conversation.
- Personalized resources to address options, ratings, contact information, and website addresses for the client to continue investigating independently.

Step 3: Assess your patient's preferences and values: Important aspects of this step include understanding and leveraging patient preferences, values, health, and general literacy in support of the decision-making process. Some of this information is gleaned during client assessments and other interactions; however, it is always the right time to validate client's preferences and values. Effective communication and listening skills are essential competencies applied in this step (CMSA, 2014; Treiger & Fink-Samnick, 2016).

Informing a client of available options is part of SDM. Some options may not be in keeping with a client's values and preferences; however, it is the client's place to choose from all options rather than from an array filtered by what a case manager believes to be acceptable within the client's preference. It may

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

FIGURE 5
Health on the Net. From Health on the Net (n. d.).

be helpful to explain your investigation process and discuss how you took a client's preferences into consideration. For instance, consider a client's linguistic preferences and needs. Investigating options and presenting them through a client's native language speaker demonstrate your due diligence to address personal preference, including linguistic needs.

Studies demonstrate that treatment decisions change after a patient becomes more informed as to available options and associated risks (Mulley, Trimble, & Elwyn, 2012; Thompson-Leduc, Turcotte, Labrecque, & Légaré, 2016). In case management, validate that options are understood. Avoid use of technical terminology. Encourage a client to talk about what matters most to him or her (NQP, 2018). Leverage communication as a tool to learn if the client/caregiver understands how a decision may affect his or her quality of life. For instance, when looking at postacute facilities, make sure to include the distance of each facility from his or her primary family member or friend. This factor may weigh into a decision more prominently once a client learns that not having regular contact with loved ones may result in isolation, loneliness, and despair, which are contributing factors to an unsatisfying quality of life and less than expected outcomes (Singer, 2018).

Demonstrate empathy in client communications (AHRQ, 2014; NQP, 2018). Express interest when a client identifies the impact that a choice may have on his or her life to prompt additional disclosure. This recognition furthers a client's realization that his or her concerns are being heard and are important to the case manager. An example of this occurs when discussing postacute placement for a client needing adult day care. After presenting community options, the client's son states that he wants his father to go to a program that aligns with his religious beliefs. The case manager, not previously aware of this desire, responds by saying

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

"I understand your father's faith is extremely important. Let's look for those possibilities". This provides an "I-hear-what-you-are-saying" acknowledgement and demonstrates the case manager's respect for a client/caregiver preference. It encourages the caregiver's continued collaboration and open discussion.

Keys to this step are as follows:

- Encourage each client to talk about what matters most to him or her.
- Use motivational interviewing techniques, including open-ended questions.
- Demonstrate interest and empathy when a client describes the life impacts of his or her condition.
- Acknowledge a client's values and preferences

*Step 4: **R**each a decision with your patient*: Time-sensitivity is an important aspect of decision making (AHRQ, 2016). That said, expecting an instantaneous choice is neither reasonable nor advisable as a person-centered approach. Be sure to include the time frame within which a decision needs to be made during the initial and subsequent conversations. In situations in which time is of the essence, gently reiterate the time-sensitive nature of making a decision rather than pushing a patient into a regrettable decision. It is helpful to include the consequences of prolonging a decision (e.g., financial liability, loss of an available bed) in the context of presenting information.

There are usually health plan/payer restrictions to consider (e.g., network restrictions) when presenting available options to a client. This does not preclude offering options that a client requests. However, it is imperative to explain the implications of going to an out-of-network facility, specifically those relating to payer coverage and potential out-of-pocket expense. For example, Mr. Bedford's transition plan is to go to a rehabilitation facility. He tells his case manager that he wants to go to Spelling, a well-known facility located about 40 miles away from home. An acceptable alternative is closer to home. The case manager investigates further and learns that Spelling is not in his plan's network. When returning to present options, the case manager uses a neutral tone to discuss both facilities. She begins the dialogue by restating Mr. Bedford's preferences before offering the pros and cons including the distance between each facility and his hometown. Then she raises the cost implications associated with admission to each facility. Rather than placing his plan in a negative light with a statement like, "Your plan doesn't cover Spelling, so I did not look further into it," she presents a document listing the cost of admission and continued stay for each facility. When faced with the sizable out-of-pocket expense of admission to Spelling, Mr. Bedford states, "I did not expect it would be that much of a difference. No matter how great the place is, I can't see paying that much money. Let's go with the other place." The case manager offered options and information so that the client could make an informed decision. In doing so, she avoided placing the patient's health plan in the role of the villain. Although this may have served an immediate need of expediting the transition plan, this approach carries a long-term impact on the working relationship between member and health plan, plus the member's confidence in his or her health plan would likely suffer.

This example raises the issue of including price and cost information in health care decision making. As price transparency gains momentum, a client's understanding of the financial aspects of care becomes even more important. The June 24th Executive Order, "Improving Price and Quality Transparency in American Healthcare," seeks to force health care providers into releasing price/cost details of health care choices (The White House, 2019). This order does not carry the force to change existing law; it is a directive to draft new rules or guidance (Keith, 2019). Including financial information to the discussion places the consumer in a more informed position when making decisions about care options. When making a large purchase such as an automobile, usually consumers comparison shop at a number of dealers to find the best value prior to making a decision. Price is often the key decision point. Up until recently, consumers have generally been blind to the cost of their health care. It appears that we are on the path to change. Case managers must be ready to present price/cost information to clients as part of the SDM experience.

A case manager's practice setting has an effect on access to price and/or cost data. Those working for plans (or other payers) have a decided advantage of easy access to both charge and payment details. This information imbalance makes it even more important for case managers to build and maintain collaborative and professional working relationships. There may also be organizational restrictions regarding disclosure of price/cost information. If such a policy or agreement exists, it is important for case managers to enlighten department leaders as to this issue so that it can be addressed with priority.

Providing a client with the charge for a service is not helpful except in a private payment situation where a client is responsible to pay 100% (or an agreed-upon percentage) of a fee. An informed decision requires that a client has all relevant financial information, which may affect his or her final decision, including but not limited to price and payment information, plan limitation(s), in and out of network ramifications, deductible, coinsurance and copayment details. This information should be presented in a clear and concise manner according to the client's preferred method of

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

communication. As presented in the previous example, it is helpful to present numbers both verbally and in writing. Allow sufficient time for the client to formulate and ask questions. If unable to respond immediately, be diligent in finding the answer and respond promptly.

Other strategies that aid decision making are process of elimination and defining have-to-have versus nice-to-have features. Either conversation begins with confirming a client's expressed priorities and preferences.

- Process of elimination—Address each option by delineating how each meets or does not meet the client's desires.
- Have-to-have—Classify preferences as being have-to-have, which are things that must be present for an option to be acceptable to a client (e.g., native-language speakers available 24/7) or as being nice-to-have such as easy access to public transportation for extended friends and family to visit.

Provide encouragement as the client considers and either confirms or dismisses each option. If the client remains undecided, consider outreach to a caregiver and/or member of the care team whose opinion matters most to the client and include that person in the SDM dialogue.

Encourage the use of decision support tools as part of the process. Although tools factor into the SDM process at any point, when someone finds it difficult to reach a decision, these tools present an opportunity to support the client's thought process apart from an extended dialogue. Many organizations develop their own tools, some rely on technology in the form of an avatar guide which the client views. The ability to use these tools efficiently and effectively is as important as having access to them. A simple explanation of their use should be provided along with a demonstration of any technology required to navigate the tool. It is recommended that decision aids be tested and/or validated prior to systemwide implementation. Examples of tested decision aids include the following:

- AHRQ's patient decision aids
- Option Grid decision aids
- The Ottawa Personal Decision Guide
- Dartmouth–Hitchcock Healthwise

Although making a decision is commendable, SDM focuses on the client making the best decision for him or herself after consideration of alternatives, risks, and benefits. Once a decision is made, confirm the client's understanding of his or her choice as well as the implications of the choice. Shared decision-making places the client in the driver's seat as to the course of his or her health care. Figuratively speaking, the case manager should ensure that the client has not been relegated to being a passenger in his or her own car.

Keys to this step are as follows:

- Frame decisions as a part of a bigger picture by providing the client with perspective (e.g., process steps, timing).
- Avoid pressuring or demanding a decision.
- Provide additional information, as needed.
- Inquire as to remaining questions or concerns.
- Use decision support tools.
- Use teach-back by asking the client to describe his or her options.
- Schedule follow-up conversations after each interaction, as needed.

Step 5: Evaluate your patient's decision: Upon confirming a decision, the case manager should pause to reflect and evaluate its quality and impact. Consider how the choice affects the case management plan of care and update the plan accordingly. Follow-up with the client to ensure that he or she remains committed to the choice. Implement the updated case management plan of care.

In long-term case management engagements, be cognizant of the fact that decision can (and should) be revisited especially if it relates to chronic condition management (AHRQ, 2014). Be sure that the client understands that as facts change and progress is made (or not made), so too may his or her choice. Monitor the impact of the decision as well as the client's reaction to interventions and changes in the case management plan of care. Continuous evaluation during the case management engagement is an essential part of the iterative case management process (CCMC, 2019d; CMSA, 2016, p. 19). This also references back to previous dialogue regarding the case management process, which was explained earlier in the engagement.

In transition of care situations, reach out to the case manager assuming responsibility for care coordination in both up- and downstream settings. In other words, transition the case management plan of care and provide an opportunity for care continuity via professional and accountable handover interactions (National Transitions of Care Coalition, 2008, p. 7).

It is important to consider that the mode in which case management practice takes place may affect how SDM is conducted. Those featuring face-to-face communication are likely to be more effective for SDM interactions than those relying on telephone or other means of communication. It is not to imply that non–face-to-face interactions are less impactful; however, it presents challenges due to the inability to interpret nonverbal cues, environmental factors, and other variables affecting communication. The method of communication must be taken into consideration during SDM design and implementation phases. Research as to the success of case management SDM effectiveness, as well as variances dependent upon case management modality is required to more fully understand the impact of delivery mode.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Arguably, the greatest benefit of SDM is its emphasis on ethically framed practice.

Keys to this step are as follows:

- Evaluate the decision and its impact(s).
- Monitor the impact following implementation of a decision.
- Review anticipated versus actual outcome to determine whether further action is needed.
- Document the case management plan of care meticulously.

As pertains to the entire SDM process, it is important to review your organization's policies and procedures that address client decision making. A thorough evaluation of each document includes its classification within a framework, which distinguishes whether its content rises to the level of requiring SDM. The implication of that process dictates the degree to which policy and process need to change in order to reflect an authentic SDM paradigm. For example, it is a common practice to provide three options to a client when considering a post–acute transition to a skilled nursing facility. As SDM deploys across the continuum, the three options approach will likely change. Box 1 provides a scenario in which a client engages in the process of post–acute facility selection. This example brings to light a consideration in the design and implementation of SDM in case management—the examination and modification of organizational policies and procedures. Shared decision-making implementation is not a case of word substitution so that all policies include the term "shared decision-making." It is a philosophical and systematic shift. Leadership must embrace the entirety of SDM and be willing to reflect the change in department and/or organization documentation as well as the impact on a case manager's performance (e.g., time, outcomes).

SDM Implications for Informed Consent to Case Management

Arguably, the greatest benefit of SDM is its emphasis on ethically framed practice. There are a multitude of scenarios in which a case manager can apply SDM to client interactions. However, of specific importance is obtaining informed consent to engage case management services. Shared decision-making lies at the heart of informed consent. There are three assumptions that apply for consent to be valid: competence, being adequately informed, and being given voluntarily as opposed to being coerced (Institute for Bioethics and Health Policy, 2019).

A deeper look into the process of ethically valid consent identifies it as being based upon mutual respect and participation, rather than as a ritual to be

BOX 1
Transition of Care

A Transition of Care Scenario in Which a Client Moves From Hospital to SNF.

Client	Case Manager
Prior to an elective admission, the client discussed the postoperative plan of care with specialty providers and precertification team. It was mutually agreed that an SNF stay was the preferred option after the hospital. Optimally, in an elective procedure situation, a patient visits one or more postacute facilities prior to hospital admission. In this scenario, site visits did not take place.	Explain the authorization process for SNF transfer. In the SDM context, the case manager should • Describe the evaluation process; the patient considers one (or more) SNF and each SNF evaluates patient abilities and needs to determine whether an appropriate and available bed exists. • Explain that the payer–provider network may not include known facilities and therefore limits patient choice. Identify client's priorities and preferences relating to the choice of facility. Help narrow down facility options based on these stated preferences and priorities. Support the evaluation process. Prepare and share a list of facilities within the client's payer network. Include a contact name and phone number to set up visits. Offer out-of-network options with caveat that health plan will probably not cover the stay. Initiate evaluations by notifying admission coordinators of transition plan and anticipated date.
The caregiver conducts site visits	Support decision-making process by raising client's previously stated priorities and preferences. If available, provide and explain sanctioned decision-making tool(s) to the caregiver. Clarify the date by which a decision is required.
Client reaches a decision	Facilitate decision making through process of elimination using client's preferences and priority. Formalize transition plan with client. Notify involved facilities of client's decision.
	Evaluate client's decision Ensure that selected facility provides level of care required to meet client's stated needs and preferences Review facility quality scores/ratings and share with client Verify that the selected facility meets patient's priorities and preferences

Note. SDM = shared decision-making; SNF = skilled nursing facility.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

TABLE 1
Informed Consent Practices in Case Management[a]

"We run everything through our legal department. We do all telephonic 'opt in' CM and we read them a general disclaimer prior to enrollment. They (the client) has the right to opt out/disenroll at any point in time." — Managed Care program
"The Care Manager requests the member's verbal acceptance of enrollment into the Care Management program and explains to the member his/her rights to decline participation at any time. Verbal consent or a request to refuse participation is documented in the program." — Managed Medicaid program
"We don't use this in my line of CM." — Worker's Compensation program
"We do not have a specific consent to CM because it is part of the overall consent to treatment signed upon admission. However, we do explain our role and work with each patient's preferences in transition planning and other activities." — Acute Care facility

[a]Quotes used with permission.

equated with reciting the contents of a form detailing the risks of a particular treatment (Braddock, 2011). The ethical foundation of informed consent promotes personal well-being and self-determination (Braddock, 2011; Shay, & Latafa, 2015;). Self-determination can be defined as autonomy. The implication is that a competent individual has the right and ability to make decisions affecting his or her life.

There may be perceived incongruity with the principle of beneficence (to do good). Beneficence refers to the notion of doing what is believed to be in the best interest of a client. Conflict arises when beneficence (of a provider) opposes autonomy (of the client). The best case scenario includes a competent client and his or her autonomous decision(s). Autonomy must be respected regardless of whether or not the decision made conflicts with the provider's own belief that another choice is in the best interests of a client (Institute for Bioethics and Health Policy, 2019).

A case manager encounters many situations in which a client exercises autonomy. The case manager's response either demonstrates his or her professional practice conforming to applicable law, regulation, code of conduct, and practice standard or represents a serious lapse of professional responsibility. Shared decision-making overlays the case manager/client dynamic in which mutual respect and understanding are key. This is reflected in informed consent, as well as medication adherence, choice of provider/vendor/supplier, and many other instances. Whether SDM takes place between the case manager and client or is one in which the case manager supports another care team member, the application of ethical principles serves as a guidepost throughout the interaction.

The existing methods of consent to case management include both verbal and written options. Seeking client consent should be preceded by an objective and clear explanation of case management. Examples of current practices are given in Table 1. Policies and processes associated with informed consent should recognize SDM as the manner in which participation is achieved. Presently, it is unclear whether that is a

TABLE 2
Professional Expectations of Informed Consent[a]

Case Management Society of America	Commission for Case Manager Certification
"The professional case manager should obtain appropriate and informed consent before the implementation of case management services" (CMSA, 2016, p. 27).	"Board-Certified Case Managers (CCMs) will provide the necessary information to educate and empower clients to make informed decisions. At a minimum, Board-Certified Case Managers (CCMs) will provide information to clients about case management services, including a description of services, benefits, risks, alternatives and the right to refuse services. Where applicable, Board-Certified Case Managers (CCMs) will also provide the client with information about the cost of case management services prior to initiation of such services" (CCMC, 2015, p. 8).
National Association of Social Workers	**American Case Management Association**
"…the social work case manager has an ethical responsibility to ensure the client has the requisite information to provide informed consent in all aspects of the case management process" (NASW, 2013, p. 22).	Does not address informed consent to case management but does mention informed choice pertaining to community care/provider options (ACMA, 2013, p. 6).

[a]From the Commission for Case Manager Certification's Case Management Code of Professional Conduct (2015); the Case Management Society of America's Standards of Practice (2016); the National Association of Social Workers Standards of Practice for Case Management (2013); and the American Case Management Association Practice Standards (2013).

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

consistent practice. Consent to case management is considered, by some, to be a formality that one must go through before the provision of services. This is the opportunity to reevaluate an organization's current approach to informed consent to case management. Document language should reflect the deliberate application of SDM as the framework within which informed consent to participate in case management is obtained.

Most practice standards and codes of conduct address informed consent (see Table 2). However, it is important to understand that standards and codes are intended to be assumed in their entirety, rather than as excerpts. A case manager should practice in a manner aligning with the entirety of applicable practice acts, standards, and conduct codes. As the use of nonprofessional staffing strategies increases across health care, it becomes important to distinguish the engagement of professional case management services from strictly administrative care coordination. Leading into SDM informed consent, a client should be made aware of

- who is providing his or her case management services,
- that provider's professional credentials, and
- exactly what services are to be performed.

In the absence of doing so, the professional case manager sinks into the ever enlarging morass of care coordination taskmasters. It is during an SDM informed consent process that consumers become enlightened as to whom they entrust their health care needs.

Another aspect for inclusion of SDM as a hallmark of professional case management is the practice standard, which highlights that a case manager should engage in scholarly activities and maintain current knowledge, best practices, skills, and competencies (CMSA, 2016, p. 30). The expansion of SDM across health care practices and settings inclusive of case management practice is a primary example of incorporating best practice into professional case management practice.

Communication skill is an essential competency in professional case management. Shared decision-making is a communication process in which case managers and clients collaborate to make the best health care decisions based on what matters most to the client.

When applicable, the process of obtaining informed consent should reflect a collaborative approach, which values and includes a person's needs and preferences rather than simply as an administrative result of targeted screening and the reading of a program description. The application of SDM as an approach to informed consent to case management is best demonstrated using a case study approach. Box 2 is an introduction to Mrs. and Mr. Manning. Table 3 expands the scenario with a process record of an SDM informed consent dialogue between Scott Popkin (case manager) and the Mannings (client/caregiver). The applicability of this exact approach may not fit every practice setting. Case managers are often faced with complicated situations. This scenario serves as an example of SDM, which does not

BOX 2
Consent to Case Management Scenario Introduction

Meet Ted and Betty Manning. Ted is a previously healthy and active 50-year-old man who is a chief executive and cofounder of an international consulting firm. In the past 2 years, he suffered a series of health crises, including a myocardial infarction and a cerebral vascular accident. He was also hospitalized for acute pancreatitis and subsequently diagnosed with insulin-dependent diabetes mellitus with early peripheral and neuropathic vascular complications. Last month, a seemingly small blister on his right foot became infected and progressed to lower leg cellulitis. His compromised peripheral circulation contributes to poor wound healing. He is now faced with deciding whether to undergo an amputation. He is seen regularly in an outpatient clinic for wound care and intravenous antibiotics. His endocrinologist and vascular surgeon both requested case management intervention.

Scott Popkin, an advanced practice registered nurse and a case manager, visits Mr. Manning at home. He introduces himself as both a nurse practitioner and a case manager. During the comprehensive interview, Mr. Manning states that he and his wife feel overwhelmed because their previously socially active and idyllic life has crashed around them. He jokes "I am the victim of alien body snatchers. I went from healthy and active to chair-bound in an instant". Scott notes that Mr. Manning feels trapped because of his limited activity from home to medical appointments that takes all the energy for the day. He feels guilty because he only contributes to the household financially. He is on an indefinite leave from work but is concerned about how long it is reasonable for him to remain in this status regardless of it being his company.

The Mannings live in a two-floor, single-family home with eight steps to enter through the front door and four to enter through the attached garage. The home underwent extensive renovation last year. The master bedroom and a full bath replaced the formal living and dining rooms on the first floor. The second floor is now used by a rare overnight visitor. As Betty shows Scott around the first floor, she confides that she is considering taking leave from her full-time job because she is exhausted from supporting all her husband's health and personal needs. She cannot deal with the stress of juggling two full-time jobs. She says that her daughter-in-law is on maternity leave and comes over with the baby to visit and takes Ted to and from his appointments. Betty feels badly taking up her time while she should be enjoying her leave. Following a brief physical examination, Scott and the couple take a seat around the kitchen table. He places a copy of the case management program brochure in front of the Mannings.

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

TABLE 3
Modified Process Recording of Informed Consent to Case Management

Scott	The Mannings	SHARE
Scott looks to the couple and notices a hint of anxiety in their furrowed brows. He smiles and asks. *What have you heard or experienced of case management?*		**Seek** participation in the conversation. Uses an open-ended question to open a dialogue.
	Mr. Manning takes the lead responds *We had case managers at the hospitals. They helped with me going to another facility or home.* Mrs. Manning adds *We have not had contact with anyone since we came home from rehab though.*	
Scott nods to acknowledge the responses and maintains eye contact. *Yes. Sometimes case managers only work within specific facilities or in a system. How I work is a bit different.* *How do you feel about having someone, such as myself, involved in coordinating your care and serving as your advocate?* *Would you like to hear about our case management program?*		**Seek** participation in the conversation. Probe for client's opinions and understanding of case management. Uses open-ended questions, where possible
	Well, it gets very unsettling at times. We aren't always sure that all the doctors we see bother to talk to each other. It is frustrating having to serve as a conduit between all of them. It would be helpful to have someone we can count on to help us sort through things. Nodding as they state, *Yes, we would like to understand your program.*	
Nodding to acknowledge concerns, *Yes, healthcare today is complicated. I understand how confusing it is. Honestly, it confuses me at times. Please know that you are not alone in feeling frustrated. This is something I frequently hear from other members. You are not alone.* *Let me tell you about our program. The case management program is a voluntary benefit offered by your health plan. I am an employee of the health plan. I work in the Medical Management Department with a team of people devoted to support people, such as yourselves, whose health care is complex.* *Please understand that one of your options is not to accept case management. Another is that you have the right to revoke your consent at any time during the engagement of case management services.* *This is a lot of information to take in. I want to make sure I've explained this clearly. Please tell me what you heard.*		Express empathy to confirm client experiences and feelings. **Help** explore and compare options

(*continues*)

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

TABLE 3
Modified Process Recording of Informed Consent to Case Management (*Continued*)

Scott	The Mannings	SHARE
	Ok, let's see if I get this. I can accept case management, but don't have to. I can also accept case management and cancel it at any time. *Does that affect my health insurance, if I cancel case management, I mean?*	
To answer your question, no. If at any point you decide to withdraw from case management, it does not affect your health coverage. It simply means that I, and members of my team, will not be involved in helping to coordinate your care and benefits. How that sounds to you?		**Help** explore and compare options
	It sounds like I won't lose my insurance coverage if I cancel case management. *Well, it sounds promising but what is this going to cost us?*	
Case management is a benefit offered by your health plan. It is free to you as a member. However, there are costs associated with the appointments, procedures, medications, products and services you need in the course of your care. I help by explaining those costs, as needed. *If you have questions, I am here to help with suggestions and answers. For example, you may need a piece of medical equipment. In that situation I explain why the equipment is needed and review your health plan benefits to share coverage and cost considerations, such as out-of-pocket costs like copayment, deductible, and co-insurance are involved. Because I understand your benefits and limitations, I can try to maximize those benefit dollars to the best of my ability.*		**Help** explore and compare options
	Okay, but what exactly do you do to help me?	
As a case manager, I work with you to make the best use of your health insurance benefits and support you in ways such as: • *Perform regular health assessments and basic lab work to assess your health* • *Coordinate your care appointments and facilitate consults to specialists* • *Educate you regarding your health conditions and care options* • *Help you to make informed decisions about your care* • *Provide you with resources, information, and referrals to address issues affecting your health and health care* • *Monitor your health status to help avoid hospital admissions or Emergency Department visits* • *Work with other case managers, such as ones who may be working at a hospital or in a doctor's office, to coordinate your care* • *Advocate for you regarding care products, and services* • *Perhaps most importantly, I support you in becoming more knowledgeable about health care and ultimately you being your best advocate through education and experience* *If you accept case management, we work together. During the initial couple weeks, we go through series of questions the answers to which give me a better perspective of your health and care. I come up with a case management plan and we talk about that as well. My goal is to understand where you are at from your perspective* *What specific questions about what I do can I answer for you?*		**Help** explore and compare options
	Well, I think that I get it. You don't give away things for free but you will help me with care coordination and making the most of my benefits. *Does that mean you will be visiting my home all the time?*	

(*continues*)

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

TABLE 3
Modified Process Recording of Informed Consent to Case Management (*Continued*)

Scott	The Mannings	SHARE
Scott smiles, *Yes, you seem to get the gist of it.* *Your question is a good one. Most of this is accomplished over the telephone but I will come to your home from time to time and as you need me to. For example, if you have a cold and don't want to go to the urgent care clinic or doctor's office. I, or someone from my team, comes to you instead.* *Always keep in mind that someone from my team, is available by phone 24 hours a day, 7 days a week. I do not take the place of your Primary Care Provider. I work in collaboration with your care team.*		**Help** explore and compare options
	And what if I decided to stop case management once we begin, what happens to me then?	
What happens is that we will have a conversation to make sure you understand the implications of disengaging case management. We review your case management plan and its current status. I provide you with a copy of your plan and/or provide a copy to your choice of provider(s). If you wish, I will call a case manager who you are transitioning to and review our case management plan. I will send a copy to that person as well. I want to be sure the transition of your care coordination is as smooth as possible upon our disengagement. *We agree upon the formal disengagement date and have a final call to close out any loose ends and my involvement in your care coordination. I also send a letter confirming our agreement and disengagement date to you, your primary provider, and any vendors, suppliers or specialists with whom I had contact.* *After our formal separation, you should keep your primary care provider's (and your new case manager's) telephone number handy in the event you have questions or concerns about your health or care.*		**Help** explore and compare options
	Ok. I guess we cross that bridge if we come to it. I'm just worried about being left on my own suddenly.	
That is understandable. If for any reason you regret the decision to disengage, call the medical management department's main line. Someone is available to talk about your concerns and options. *If case management sounds like too much interaction for you, there is another option to consider. We have programs focusing on health condition education and coaching. Each focuses on a specific health condition, such as diabetes, stroke and heart attacks survivors.* *These programs are conducted over the Internet and include scheduled telephone calls with a dedicated health coach. That person works with you to understand your health condition and what you can do to improve your overall health. Programs like this do not include care coordination however, if you desire, your health coach can contact case management to reach out to you at that time.* *Another option for you to investigate is if one of your healthcare providers has a case manages working within his/her office. You could call and ask if you qualify for that program and seek out case management from that source.*		**Help** explore and compare options
	Well, that makes me feel better about not being abandoned. It also gives me other choices to consider.	
Scott pauses to give Mr. Manning time to continue his response before stating, *You are truly in the driver's seat. You have the right to accept or reject any or all of these options.*		
	Thank you. All this helps. I don't have to participate if I don't want to and I can change my mind at any time. What is the downside of this case management program?	

(*continues*)

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

TABLE 3
Modified Process Recording of Informed Consent to Case Management (*Continued*)

Scott	The Mannings	SHARE
That's a great question and before I respond, I have questions for you to consider, *How much time do you and your wife spend trying to coordinate appointments, medications, and other health care-related things? Is it important for you to have more time to do other things? What is most important to you in terms of your quality of life?*		**Assess** preferences and values
	The Mannings look at each other, rolling their eyes in frustration before responding, *We spend way too much of our time on trying to figure out claims and benefits. It's the focus of our existence most days. It is actually the main cause of arguments between us. We never used to argue. Now it's almost an everyday occurrence.*	
I hear your frustration. I can only imagine how I would react were I in your shoes. I witnessed how chronic illness affected by parents. I may not be able to do everything or solve every problem that arises but I will do my best to help make your health care more coordinated and as cost-effective as possible. *In your case, there may be downsides but that depends on how you define downside. Do you consider my having access to your medical information, involvement in your care or me talking to your healthcare providers as downsides? Help me to understand your concerns.*		**Assess** preferences and values Express empathy and share previous experience(s).
	Mr. Manning speaks up, *My main concern is does this put more layers of bureaucracy between myself and my doctors? My situation is already complex enough.*	
Great question! I do not come between you and your doctors. If you wish to speak to any of your providers, call them directly. I do not need to be involved. You do not have to tell me every time you speak to any other care team members but it is helpful for me to understand and adjust your case management plan as needed. I'm not a barrier to your providers. If you ever feel as though I am getting in the way or have any other concerns about case management and what we are doing, please talk to me about it. Does this address your concern?		**Assess** preferences and values
	Yes, that helps. Thank you. I guess the only one is what do we have to do to sign-up?	**Reach** a decision with your patient
Scott smiles and picks up the case management brochure from the table as he continues, *This brochure includes important information regarding how our case management program works. It also has our main phone number should you need to call. This is my business card which contains my specific contact information. Put this in a handy place. If I am not working, your call goes to someone else on my team who is qualified to help you. Do you have any questions about what I've told you so far?*		**Reach** a decision with your patient **Evaluate** your client's decision

(*continues*)

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

TABLE 3
Modified Process Recording of Informed Consent to Case Management (*Continued*)

Scott	The Mannings	SHARE
	Shaking their head, *No. It has been pretty clear so far.*	
Scott takes a consent form from his briefcase and places it in front of the Mannings as he continues, *This is our consent to case management form. Because case management is voluntary, you must consent to participate in the program.* *Signing this form allows me to enroll you in our case management program. It also allows me to contact other members of your care team, such as hospitals where you received care, doctors, therapists, suppliers, etc. on your behalf and to have access to your healthcare information in order to completely assess and develop your case management plan of care.* *As I am developing your case management plan, you and I continue to talk on the phone and review the plan. I send you a copy of the drafted plan and we review and approve or reject various aspects. It's similar to devising a contract, something that you are very familiar with, I'd imagine.*		**Reach** a decision with your patient **Evaluate** your client's decision
	Mr. Manning smiles, *Yes, a bit. This makes perfect sense.*	
Ok, I'll keep going. Scott points to the following text on the form, *Do you understand that you can revoke your consent to case management at any time and for any reason and do you agree that you have read or have been read this consent form and you understand the information in this consent form?* Scott looks to both Mrs. and Mr. Manning for confirmation and verbal agreement.		Continue to **help** explore and compare options **Evaluate** your client's decision
	Yes, I understand that our consent is revocable at any time. Mr. Manning turns to his wife to confirm. *Yes, I understand as well.*	
Scott pulls out a copy of the Member's Rights and Responsibilities and places it in front of the Mannings. *This document lists our plan's Member's Rights and Responsibility.* Scott finishes reading through both sections and asks, *Do you understand your rights and responsibilities as a member of our plan?*	Yes, we understand. Mr. Manning turns to his wife to confirm. *Yes, I understand as well.*	**Reach** a decision with your patient **Evaluate** your client's decision
Scott returns to the consent form, pointing to the signature section, *We talked about our case management program and your rights and responsibilities as a plan member, if you wish to consent to case management please sign here.*		**Reach** a decision with your patient **Evaluate** your client's decision
	I, my wife and I are hopeful that you will be able to help us get through the challenges of our current fiasco. Mr. Manning picks up the pen and signs the form.	
Please know that while you are facing significant health challenges and major changes in your life, I have worked with many people in similar situations. You are not alone.		

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

factor in all of these additional factors. However, the process is both duplicatable and modifiable to suit the needs of an individual or organization.

Conclusion

Communication skill is an essential competency in professional case management. Shared decision-making is a communication process in which case managers and clients collaborate to make the best health care decisions based on what matters most to the client. Professional case managers must understand the concepts and principles of SDM as applicable in their respective practices. To formalize this client-centered approach, case management documentation should incorporate SDM concepts and case managers should be educated as to the implementation and use of SDM in practice. Further study of SDM's impact in a variety of case management applications and its impact on case management outcomes is strongly encouraged. Updating language within practice standards, conduct codes, program descriptions, individual performance plans, satisfaction surveys, and department/organization goals carries particular importance as these documents lay the foundation for professional case management practice. In the absence of organizational support, case managers should evaluate and integrate SDM into their professional practice toolbox.

References

Agency for Healthcare Research and Quality (AHRQ). (2014). *Informed medical decisions foundation: Tools for providers*. Retrieved July 8, 2019, from https://innovations.ahrq.gov/qualitytools/informed-medical-decisions-foundation-tools-providers

Agency for Healthcare Research and Quality (AHRQ). (2016). *The SHARE approach: A model for shared decision making*. AHRQ Publication No. 14-0034-2-EF. Retrieved May 30, 2019, from https://www.ahrq.gov/sites/default/files/publications/files/share-approach_factsheet.pdf

American Case Management Association (ACMA). (2013). *Standards of practice & scope of services for health care delivery system case management and transitions of care (TOC) professionals*. Retrieved June 15, 2019, from http://www.acmaweb.org

Boland, L., Graham, I. D., Légaré, F., Lewis, K., Jull, J., Shephard A., ... Stacey, D. (2019). Barriers and facilitators of pediatric shared decision-making: A systematic review. *Implementation Science*, *14*(7), 2–25. Retrieved July 1, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/30658670

Braddock, C. H. (2011). *Supporting shared decision making when clinical evidence is low*. Effective Health Care Program website. Retrieved June 7, 2019, from https://effectivehealthcare.ahrq.gov/sites/default/files/braddock.pdf

Braddock, C. H., Edwards, K. A., Hasenburg, N. M., Laidley, T. L., & Levinson, W. (1999). Informed decision making in outpatient practice. *Journal of the American Medical Association*, *282*(24), 2313–2320. Retrieved June 7, 2019, from https://jamanetwork.com/journals/jama/fullarticle/192233

Case Management Society of America (CMSA). (2014). *.e4: Engage, empower, enhance, enable*. Retrieved from http://solutions.cmsa.org/acton/fs/blocks/showLandingPage/a/10442/p/p-0015/t/page/fm/0/r/-/s/?sid=TV2:7nNvPURis. Accessed on June 15, 2019.

Case Management Society of America. (2016). *CMSA standards of practice for case management, revised*. Introduction. Retrieved May 2, 2019, from http://cmsa.org/sop

Commission for Case Manager Certification (CCMC). (2015). *Code of professional conduct for case managers*. Retrieved July 4, 2019, from https://ccmcertification.org/sites/default/files/docs/2018/ccmc-18-code-of-conduct_1.pdf

Commission for Case Manager Certification (CCMC). (2019a). *Definition of case management*. Mount Laurel, NJ: Author. Retrieved May 3, 2019, from https://ccmcertification.org/about-ccmc/about-case-management/definition-and-philosophy-case-management

Commission for Case Manager Certification (CCMC). (2019b). *The client–case manager relationship*. Retrieved June 4, 2019, from https://www.cmbodyofknowledge.com/content/client-case-manager-relationship

Commission for Case Manager Certification (CCMC). (2019c). *Philosophy of case management*. Retrieved July 2, 2019, from https://www.ccmcertification.org/about-ccmc/about-case-management/definition-and-philosophy-case-management

Commission for Case Manager Certification (CCMC). (2019d). *Case management process*. Retrieved June 14, 2019, from https://www.cmbodyofknowledge.com/content/case-management-process-1

Daly, R. L., Bunn, F., & Goodman, C. (2018). Shared decision-making for people living with dementia in extended care settings: A systematic review. *British Medical Journal Open*, 8, e018977. Retrieved June 1, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/29886439

de Mik, S. M. L., Stubenrouch, F. E., Balm, R., Ubbink, D. T. (2018). Systematic review of shared decision-making in surgery. *British Journal of Surgery, 105*(13), 1721–1730. Retrieved June 1, 2019, from https:// www.ncbi.nlm.nih.gov/pubmed/30357815#

Friedberg, M. W., Van Busum, K., Wexler, R., Bowen, M., Schneider, E. C. (2013). A demonstration of shared decision making in primary care highlights barriers to adoption and potential remedies. *Health Affairs*, *32*(2), 268–275. Retrieved June 2, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/23381519

Gionfriddo, M. R., Leppin, A. L., Brito, J. P., Leblanc, A., Shah, N. D., Montori, V. M. (2013). Shared decision-making and comparative effectiveness research for patients with chronic conditions: An urgent synergy for better health. *Journal of Comparative Effectiveness Research*, *2*(6), 595–603. Retrieved June 2, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/24236798

Health on the Net (HON). (n. d.) *Certification*. Retrieved May 30, 2019, from https://www.hon.ch/en/certification.html

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Institute for Bioethics and Health Policy. (2019). *Decision making: Autonomy, valid consent, and guardianship*. Miller School of Medicine website. Retrieved June 7, 2019, from https://bioethics.miami.edu/education/ethics-curricula/geriatrics-and-ethics/decision-making-autonomy-valid-consent-and-guardianship/index.html

Institutes of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Committee on Quality Health Care in America. Washington, DC: The National Academies Press.

Jensen, T. S., Chin, J., Ashby, L., Dolan, D., Canos, D., Hutter, J. (2018). *National coverage determination for implantable cardioverter defibrillators*. Retrieved May 6, 2019, from https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=288

Keith, K. (2019). *Unpacking the executive order on health care price transparency and quality*. Health Affairs Blog. Retrieved June 26, 2019, from https://www.healthaffairs.org/do/10.1377/hblog20190625.974595/full/

Makoul, G., Clayman, M. L. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling*, *60*(3), 301–312. Retrieved June 30, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/16051459

Mulley, A., Trimble, C., Elwyn, G. (2012). Stop the silent misdiagnosis: Patients' preferences matter. *BMJ*, *345*, e6572.

National Association of Social Workers (NASW). (2013). *NASW standards for social work case management*. Retrieved June 16, 2019, from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0

National Quality Partners (NQP). (2018). *NQP playbook: Shared decision making in healthcare*. Retrieved May 30, 2019, from http://www.qualityforum. org/National_Quality_Partners_Shared_Decision_Making_Action_Team_.aspx

National Transitions of Care Coalition (NTOCC). (2008). *Transitions of care measures*. NTOCC website. Retrieved July 4, 2019, from http://www.ntocc.org/Portals/0/PDF/Resources/TransitionsOfCare_Measures.pdf

Richmond, M. E. (1901). Charitable co-operation. In Barrows I. C. (Ed.), *Proceedings of the National Conference of Charities and Correction*. Retrieved May 20, 2019, from https://archive.org/stream/proceedingsnati13sessgoog#page/n319/mode/2up. Accessed.

SAMSA-HRSA Center for Integrated Health Solutions. (n. d.). *Motivational interviewing*. Retrieved June 26, 2019, from https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing

Sewell, J. (2019). *Informatics and nursing: Opportunities and challenges* (6th ed.). Philadelphia, PA: Wolters Kluwer.

Shay, L. A., Latafa, J. E. (2015). Where is the evidence? A systematic review of shared decision making and patient outcomes. *Medical Decision Making*, *35*(1), 114–131. doi:10.1177/0272989X14551638

Singer, C. (2018). Health effects of social isolation and loneliness. *Journal of Aging Life Care*. Retrieved May 30, 2019, from https://www.aginglifecarejournal.org/health-effects-of-social-isolation-and-loneliness/

The White House. (2019, June 25). *Executive order on improving price and quality transparency in American healthcare to put patients first*. Retrieved June 26, 2019, from https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

Thompson-Leduc, P., Turcotte, S., Labrecque, M., Légaré, F. (2016). Prevalence of clinically significant decisional conflict: an analysis of five studies on decision-making in primary care. *BMJ Open*, *6*, e011490. doi:10.1136/bmjopen-2016-011490. Retrieved May 5, 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4932317/

Tomlin, K., Walker, D., Grover, J., Arquette, W., Stewart, P. (2005). *Motivational interviewing: Enhancing motivation for change*. Retrieved June 26, 2019, from https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing#resources

Treiger, T. M., Fink-Samnick, E. (2016). *COLLABORATE for professional case management: A universal competency based paradigm*. Philadelphia, PA: Wolters Kluwer.

Veatch, R. M. (1972). Models for ethical medicine in a revolutionary age. *Hastings Center Report*, *2*(3), 5–7. Retrieved May 30, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/4679693

Suggested Reading

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., ... Barry, M. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine, 27*(10), 1361–1367. Retrieved June 11, 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445676/

Institute of Credentialing Excellence. (2014). About us. Retrieved June 16, 2019, from http://www.credentialingexcellence.org/p/cm/ld/fid=32

National Advisory Council on Nurse Education and Practice. (2019). *Promoting nursing leadership in the transition to value-based care, draft (15th report)*. Retrieved June 16, 2019, from http://www.hrsa.gov

National Commission for Certifying Agencies (NCCA). (2019). *NCCA accreditation*. Retrieved June 16, 2019, from https://www.credentialingexcellence.org/p/cm/ld/fid=86

O'Connor, A., Stacey, D., Jacobsen, M. (2011). *Improving practitioners' decision support skills*. Decision Support Tutorial. Ottawa, Ontario, Canada: Ottawa Hospital Research Institute. Retrieved May 5, 2019, from https://decisionaid.ohri.ca/ODST/pdfs/ODST.pdf

Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry*, *16*, 146–153.

Stacey, D., Bennett, C. L., Barry, M. J., Col, N. F., Eden, K. B., Holmes-Rovner, M., Thomson, R. (2011). Decision aids for people facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews*, (10), Art. No.: CD001431. doi:10.1002/14651858.CD001431.pub3

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.

Veroff, D., Marr, A., Wennberg, D. E. (2013). Enhanced support for shared decision making reduced costs of care for patients with preference-sensitive conditions. *Health Affairs*, *32*(2), 285–293. Retrieved June 30, 2019, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0941

Teresa M. Treiger, MA, RN-BC, CCM, FABQAURP, is a thought leader inspiring Conscious Case Management practice across the health care continuum. She is principal of her own company, Ascent Care Management, providing private case management, professional education, peer mentoring, and publication services. Teri has spoken across the United States and internationally on topics such as professionalism in practice, collaborative practice, transition of care, challenges to practice with the addicted client, integrated case management, and case manager self-care. She is a prolific author in journals and books, most recently as coeditor and contributing author of CMSA Core Curriculum for Case Management, 3rd edition (with Dr. Hussein Tahan) and coauthor of COLLABORATE for Professional Case Management: A Universal Competency Based Paradigm (with Ellen Fink-Samnick). Teri is a featured columnist in Professional Case Management's The Heartbeat of Case Management. She serves as a Commissioner for the Commission for Case Manager Certification and is a past National President of the Case Management Society of America (CMSA). She was a founding board member of the National Transitions of Care Coalition. Teri is married and lives with her husband Dave in Quincy, Massachusetts. She enjoys traveling the world and actively supports domestic and wild animal rescues and shelters.

For more than 34 additional continuing education articles related to Case Management topics, go to NursingCenter.com/CE

Instructions:

- Read the article. The test for this CE activity can only be taken online at www.nursingcenter.com/ce/PCM.
- You will need to create (its free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 14 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.

Continuing Education Information for Certified Case Managers:

This Continuing Education (CE) activity is provided by Lippincott Professional Development and has been preapproved by the Commission for Case Manager Certification (CCMC) for 1.5 contact hours. This CE is approved for meeting the requirements for certification renewal.

Registration Deadline: February 28, 2021

Continuing Education Information for Certified Professionals in Healthcare Quality (CPHQ):

This continuing education (CE) activity is provided by Lippincott Professional Development and has been approved by the National Association for Healthcare Quality (NAHQ) for 1.5 CE Hours. CPHQ CE Hours are based on a 60-minute hour. This CE is approved for meeting requirements for certification renewal.

This CPHQ CE activity expires on February 28, 2021.

Continuing Education Information for Nurses:

Lippincott Professional Development will award 1.5 contact hours for this continuing nursing education activity.

LPD is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749. LPD is also an approved provider by the District of Columbia, Georgia, and Florida CE Broker #50-1223.

The ANCC's accreditation status of Lippincott Professional Development refers only to its continuing nursing educational activities and does not imply Commission on Accreditation approval or endorsement of any commercial product.

Registration Deadline for Nurses: February 28, 2021

Disclosure Statement:

The authors and planners have disclosed that they have no financial relationship related to this article.

Payment and Discounts:

- The registration fee for this test is $17.95
- CMSA members can save 25% on all CE activities from *Professional Case Management*! Contact your CMSA representative to obtain the discount code to use when payment for the CE is requested.

DOI: 10.1097/NCM.0000000000000427

Copyright © 2020 Wolters Kluwer Health, Inc. Unauthorized reproduction of this article is prohibited.