

AAMCN

American Association of Managed Care Nurses

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Care Management Institute Guidelines

Formed by the American Association of Managed Care Nurses CMI Committee

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AAMCN CMI Guidelines

Foreword

The American Association of Managed Care Nurses (AAMCN) launched the Care Management Institute (CMI) in 2006 to establish guidelines for Care Management (CM). Today, a year later, the CMI team is pleased to share the guidelines with the general membership, the nurses that perform Care Management functions regardless of the care setting, and the employer groups that have been grappling with ways to define or measure CM contribution.

It is our hope that these guidelines will be a welcome resource for health care professionals seeking a concise and consistent methodology for CM assessment or implementation.

The CMI is pleased to sponsor the publication of these guidelines, but their relevance is by no means limiting to a role or to a specific setting. The measures described in this publication are only designed to provide a framework for many practice settings that complement evidence-based practice guidelines or standards such as InterQual and Milliman-USA care guidelines, CMS standards and the like.

I am pleased to introduce this publication and I am especially pleased with the work of the CMI Committee members who have been meeting regularly, despite their busy work schedules and differing time zone challenges in order to deliver such guidelines. We hope that this publication provides a clear, efficient, and objective empowerment tool for Care Managers everywhere.

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CMI Committee Chair

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Care Manager Title Definition

Care Managers are, primarily, patient advocates striving to deliver the best care at the right time and in the most cost-efficient quality outcomes. Care Management is all encompassing of the many roles that case managers have, be it in an inpatient or outpatient setting, home health setting, workers' compensation setting, managed care setting, disease management or home-based. All of these roles involve coordinated care efforts that manage clients beyond a specific "case" or "situation" and provide them with a wide spectrum of services directed at behavioral change and healthy life styles, and optimal outcomes that last beyond the "episodic" nature of the encounter with the health care system.

Expertise/Credentials Necessary for the Role

The CMI Committee recommends the following expertise and credentials for the care manager:

- Registered Nurse
- Certified Case Manager (CCM) requirement
- Proficiency in CMS Guidelines, Milliman & InterQual care guidelines, & Standards set by Children's Health Insurance Program (CHIP) and TRICARE (previously called CHAMPUS: HMO-like Program with low cost-sharing for civilian medical services provided to active-duty and retired military personnel and their dependents)
- Three years of clinical experience (generally)
- Knowledge of URAC, NCQA, or CM standards of practice.
- Maintenance of Continuing Education appropriate to care management and renewal of any certifications
- Demonstrated accountability and skills in analysis, decision making, time management and oral, written communication
- Familiarity with available resources that include any applicable regulations, reimbursement guidelines, community resources
- Additional Certifications or academic preparation relating to care management
 - CMCN
 - CPUR/CPUM
 - CDMS
 - CPHQ
 - CDE
 - NP/PA
 - CNS

The CMI acknowledges that social workers are an important aspect of care management, however; these guidelines are directed towards clinically trained nurse care managers.

Case-Load

The care manager case-load is dependent on the practice setting and the type of population served. As a general guideline, taking into consideration the diversity of functions per setting, case-load is a range that is dependent on population served and the type of service delivery: payer side vs. provider side.

Recommended Monthly Case-Loads for Specific Settings

- MCO/HMO 40 to 75
- Inpatient (Hospitals) 35 to 40
- Disease Management 75 to 100
- Community based CM 100 to 140
- Worker's Compensation 15 to 20
- Home Health 20 to 30
- Inpatient (SNF) 50 to 60
- IMPA/PMG/MSO 50 to 70
- Advanced Care Planning (Hospice/Palliative Care) 15 to 20
- Ambulatory 20 to 30

The above case-loads are recommendations based on the collective knowledge and experience of our committee members. Case-loads do vary based on geographic location, settings and complexity. Also, please keep in mind that case-loads are constantly rolling numbers.

Why performance measures and how were the 4 categories decided?

Consistent with Cesta's definition of Nursing Case Management as "a nursing care delivery system that supports cost-effective, patient outcome oriented care," Care Management focuses on coordination and continuity of care and directs delivery of care services for optimal outcomes and optimal use of resources. Regardless of setting, care management is charged with responsibility of establishing goals and objectives and programs to ensure safe delivery of quality effective care, and favorable outcome for the client-base as well as the organization itself (Rossi 2003, pp. 360-361).

The literature review suggests a consistency in the process of defining goals, necessary data inclusive of benchmarks, and the processes to use in order to measure Care Management's effectiveness. A common prevailing challenge is the selection of outcomes that are specific to the "line of business" of an organization as well as the selection of a system that makes data useful and meaningful for that purpose (Rossi 2003, p. 745; Cesta and Tahan 2003, p. 286). Similarly, Cesta and Tahan state that outcome measures for evaluating Care Management are organization-specific and can range from meeting expected care outcomes as stated in the mission and goals and objectives of the organization, to meeting a stated length of stay (LOS), cost per day/case, or reimbursement denials. The authors further list a classification of measurable outcomes: Clinical, Financial, Quality of life, and Satisfaction (Cesta and Tahan 2003, pp. 286-287). Cesta and Cohen discuss consistent themes in evaluating Care Management services inclusive of improved quality of care, controlled resource utilization, reduced LOS, and improved satisfaction (Cesta and Cohen 2005, p. 28); and in the use of evidence-based practice and organizational features in the use and application of evidence-based practice (Cesta and Cohen 2005, p. 577).

In summary, the Care Management Institute (CMI) elected to use the following consistent themes for measuring the effectiveness of CM services. It is the CMI's hope that CM professionals, as well as the diverse organizational settings for CM services delivery, will find them useful.

Performance Measures

Category	Performance Measure
Clinical Outcomes	<p>Improved overall patient care metrics as set by evidence practice medicine (EPM) and recommended guidelines for the main disease categories:</p> <ul style="list-style-type: none"> • Compliance with practice guidelines that are widely set for disease state/conditions that result in most health care expenditures as revealed in the literature (i.e. Heart Failure, Diabetes, Hypertension, COPD/ Asthma, Pneumonia, Depression, and Stroke). • Adherence to disease specific, evidence based guidelines for all chronic conditions as well as preventative and curative care measures. • Reduced emergent/urgent care utilization • Medication compliance • Pharmacy/Prescription utilization involving step therapy & documented functionality • Adherence to diet regimens as suggested by monitoring through PCP, Dietitian/ Nutritionist, and/ or NP/PA • Clinical markers, such as BP, HbA1C, and the like falling within normal ranges. • Safe transmissions of care • Reduced acute care readmissions
Financial Outcomes	<ul style="list-style-type: none"> • Reduced Admits/1000 reports • Reduced Beddays/1000 reports • Reduced ER admissions report • Reduced generic drug use/cost report • Increase in mail-orders of “standing” treatments/prescriptions • Reduced out-of-network (OON) providers’ claim payment • Reduced volumes of appeals and grievances over turn or punitive costs • Improve hospital and ER utilization • Improved Medical Loss Ratio (MLR) • Improved use of formulary and generic medication
Operational Outcomes <p>* Operational Outcomes are suggestions and often are based on each organization’s accreditation standards.</p>	<ul style="list-style-type: none"> • Improved x% results on member satisfaction surveys • Improved x% results on provider satisfaction surveys • Reduced volumes of appeals and grievances; listed in the above metric • Improved Health Outcome Survey (HOS) surveys • Improved compliance audit results x assigned per target area: effectiveness of

	<p>care, network, contracting, access to care, etc.</p> <ul style="list-style-type: none"> • Minimum of 90% CM assessment rate for all new members that meet assessment triggers through Health Risk Assessment (HRA) surveys • Provider and patient satisfaction at 90% or greater • Improved compliance with standards of care 90% or greater for CM assessments for all new members that meet triggers through HRA
<p>Behavioral Outcomes</p>	<p>Depending on the focal point of population-focused care and disease entities, the following metrics can be monitored per CM intervention strategy:</p> <ul style="list-style-type: none"> • Adherence to an exercise/fitness program measured by 2-3x/week participation • Adherence to diet regimen measured by weekly/monthly monitoring by a dietitian/nurse/PCP • Adherence to counseling sessions, such as smoking cessation, group meeting, AA/detox treatment, f/u meetings. • Adherence to prescribed medications measured through pharmacy reports of filled prescriptions on schedule • Improved results on the “mini-mental state” (MMS) assessment reports • Improved adherence to preventive, curative and prescribed evidenced based treatments • Improved status for behavioral testing from initial baseline

References

Cesta, Toni G. and Hussein A. Tahan. (2003). *The Case Manager’s Survival Guide (2nd edition)*. St. Louis, MO: Mosby.

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**Acknowledgements
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