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Leveraging Big Data Analytics within Healthcare
Timothy M. Snavely RN, BSN, MHA

Summary
To provide a relevant review of the current literature to ascertain the potential benefits of large-scale data type usage (i.e. big data) in healthcare analysis. The topic of big data is relevant and critical in modern healthcare because the appropriate capture and analysis of it can offer solutions to the quality, cost, and access issues that plague our current system. The emerging and rapidly changing field of big data analytics shows significant promise within healthcare endeavoring to improve healthcare delivery within the United States of America.12

Key Points
• Define the burgeoning field of large-scale data analytics, to discuss the opportunities and challenges, to identify gaps in research, and to address implications for the future.
• Provide an empirical and numerical synopsis on big data analytics and to demonstrate evidenced-based need for continued research and practice. A systematic evaluation of the literature was conducted by reviewing no less than 100 relevant sources using scholarly search engines to include Google Scholar, ABI/INFORM, and EBSCOhost.
• Support the Triple Aim of reducing costs, augmenting the health of populations, and improving the patient experience of care.19

HEALTH INFORMATION TECHNOLOGY IS FOUNDATIONAL to the Unites States’ healthcare system as modern healthcare continues to evolve and improve. Advances in health informatics and information technology and systems have led to a “data explosion” whereby enormous sums of health data are being generated exponentially.9 In fact, by 2011 U.S. healthcare organizations had generated 150 exabytes of data.18 Moreover, “data has gotten so big that some 41 percent of healthcare executives say the data volume their organization manages has increased by a whopping 50 percent just from a year ago”9. This data must be skillfully and efficiently gathered, stored, analyzed, and harnessed if we are to make a lasting impact on the cost, quality, and population health goals set forth by the Institute for Healthcare Improvement’s Triple Aim. Therefore, the intent of this essay is to examine large-scale data type (i.e. big data) usage within healthcare and to demonstrate its promise and potential toward the improvement of our threatened system.

Description of the Problem
The United States healthcare system is one characterized by escalating spending, fragmented care, marginal quality, and less-than-optimal population health management.17 In fact, to describe our unique delivery model as a “system” is inaccurate; rather, it functions more like a kaleidoscope of financing, insurance, delivery, and payment mechanisms that are loosely coordinated.17 American healthcare has a convoluted history that has led us to this point; however, with the advent of new technology, complex healthcare delivery systems, data aggregation, and numerous payors, insurers, healthcare providers, and regulatory agencies, concerns have become more pronounced over the past few decades.7

In part, the cause of our marginal system lies in how our citizens interpret healthcare. The United States possesses a capitalistic and entrepreneurial view of healthcare delivery that is firmly rooted in our cultural beliefs and attitudes. In other words, the predominant view of healthcare in America is that it is regarded as an economic good/service as opposed to a public resource.17 As a result, this line of thinking spans across the US healthcare system, though that notion is rapidly changing especially with the recent passage of the Affordable Care Act in 2010.17

The issue is pervasive and puts us on an economically unsustainable path necessitating that healthcare leaders consider possible resolutions to the growing crisis in a most urgent manner. One such solution is the effective and operational use of big data. Big data is “…large volumes of high velocity, complex, and variable data that require advanced techniques and technologies to enable the capture, storage, distribution, management and analysis of the information.”15 To put it another way, it is a term used for massive amounts of healthcare information that can be interpreted by analytics to provide an overview of trends or patterns. Through
the use of large-scale data analytics via sophisticated health information technology/information systems (IT/IS), the aim is to reverse these trends resulting from our incoherent and sub-par system. Big data healthcare analytics is an emerging field generating excitement and growing interest among government entities, administrators, clinicians, researchers, and consumers. Though challenges exist and additional research is needed, the optimism for continued investment in big data healthcare analysis IT/IS is substantial.

Method
A systematic evaluation of the literature was conducted by reviewing no less than 100 relevant sources using scholarly search engines to include Google Scholar, ABI/INFORM, and EBSCOHost in order to provide an empirical and numerical synopsis on big data analytics and to demonstrate evidenced-based need for continued practice and research. In addition to scholarly and peer-reviewed sources identified via the referenced databases, professional organizations addressing current and pertinent topics in healthcare technology were cited.

Findings
Within the promising field of big data technology, some organizations have discovered tangible benefits from its operational usage. The Durkheim Project, a partnership between the Veteran’s Health Administration (VHA) and Facebook, successfully introduced a voluntary program that tracked veterans’ mobile phone numbers and social media accounts designed to mitigate suicide risk. The Carolinas Healthcare System operationalized big data technology and effectually reduced nosocomial and iatrogenic conditions, improved labor productivity, enhanced physician decision-making, and better ascertained facility supply expenditures. The positive outcomes can be observed outside of this country as well. In an effort to optimally manage population health, Germany developed predictive modeling and risk stratification tools using big data input. These tools assist in the identification of patients at risk and optimization of reimbursement models. Big data demonstrates significant potential in curbing health care expenditure growth. One study, conducted by the Booz-Allen-Hamilton Firm, a management and technology consulting firm based in San Antonio, Texas, concluded that big data has the potential to “save the US healthcare system approximately $300 billion annually in value in the health care sector, most of which is generated by lowering healthcare expenditures.” Two additional studies indicated that cost-reduction through an optimal management of high-cost patients, a reduction in preventable hospital readmissions, and an improvement in triage can save significant sums of money to the US healthcare system. Fraud and abuse indirectly affect healthcare expenditures as well. In 2011, The Center for Medicare and Medicaid Services (CMS) recovered $4 billion in costs from fraud detection and prevention using big-data tools and software. When big data is gathered, interpreted, and employed effectively, demonstrated value in personalized medicine for patients with certain health conditions and enhancement of clinical decision support systems permitting tailored treatment to individual patients results. Moreover, the execution of big data leads to cost-effective care for high consumers of health care, reduction in adverse outcomes and hospital readmissions, and treatment optimization for both individuals and populations.

Discussion
The transformative benefit from big data demands more than the adequate collection of it. Data that only serves to illustrate that a problem exists is not sufficient; rather, the solution, in part, to our healthcare dilemmas lies within the interpretation and analysis of it that results in improved health outcomes for a population. Big data analytics has already begun to validate returns on investment for a number of health care systems, both domestically and internationally. In addition, the promise and potential for improvements in clinical operations, research and development, public health, evidence-based medicine, genomic analytics, fraud analysis, and patient profile analytics is clearly recognized and documented throughout healthcare literature.

Yet, despite the optimism, challenges exist. First, relevant stakeholders must not only understand and appreciate the value big data offers but also act upon the insights it affords. For example, healthcare payors may balk at analytical outcomes since they are inclined to focus more upon “what is and what is not covered rather than what is and is not most effective.” Similarly, physicians who rely solely on their own intuition and judgment as opposed to solid evidence-based practices subvert the benefits of big data. Second, issues of privacy are a major concern. As the volume of data continues to increase, so does the possibility of a breech in information systems; “security and privacy issues are at the focal point as emerging threats and vulnerabilities continue to grow.” Third, data transparency can lead to ethical dilemmas. For example, healthcare providers may exploit this data to further their own proprietary interests rather than the needs of the community in which they serve. Fourth, data complexity, volume, variety, and velocity lead to storage and transport issues. In addition to the challenges posed, further research is needed in key areas to include: bridging the gap between data collection and its tangible use in the advancement of healthcare discovery and innovation and evaluating long-term costs and benefits of big data healthcare analysis.

Conclusion
The deployment of large-scale data type (i.e. big data) usage has shown promise and potential for multiple stakeholders within the US healthcare system. The fundamental value it offers is the possibility, even likelihood, that it will move us closer toward achieving the Triple Aim goals laid out by the Institute for Healthcare Improvement. Although challenges and needs for further research exist, the nascent field of big data technology and analytics warrant continued support and exploration.

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Developing Medical Policies Using an Evidence-Based Method: The Health Plan Approach

Suzanne Forbes, RN, CMCN, CCM

Summary

Medical policies are developed by many Health Plans and managed care organizations to assist the clinical utilization management (UM) staff in making appropriate medical necessity decisions for services that require medical review and prior authorization. Typical services that require medical review include medical, surgical, behavioral procedures, equipment, devices, laboratory tests and pharmaceuticals that could be potentially cosmetic, investigational or experimental or in need of medical necessity review criteria. Developing medical policies using evidence-based methods safeguards quality of care for the patient and provider community and are an important part of the clinical decision making process. Medical Policies help ensure that the Health Plans membership receive safe and effective care that is appropriate and of therapeutic benefit with a positive impact on health outcomes.

Key Points

• Managed Care Health Plans use a systematic evidence-based approach for the development of medical policies that includes a thorough review of the peer-reviewed published medical evidence.
• There must be sufficient evidence from medical or scientific literature to identify if the technology has therapeutic value, beneficial effect on health outcomes, and therapeutic advantages over established alternatives.
• The strength of the evidence regarding a medical technology is used to determine whether the service is safe and effective and the impact on patient net health outcomes.
• The strongest evidence is a large randomized double-blinded controlled clinical trial that compares the technology to standard treatment/testing.
• Technology assessment tools are used to facilitate evidence-based decision making and involves a critical appraisal of the published evidence.
• Policy development using evidence-based approach safeguards the quality of care for the patient and provider community and are an important part of the clinical decision making process.

MEDICAL POLICIES ARE DEVELOPED BY MANY Health Plans and managed care organizations to assist the clinical utilization management (UM) staff in making appropriate medical necessity decisions for services that require medical review and prior authorization. Typical services that require medical review include the following medical technologies: medical, surgical, behavioral procedures, equipment, devices, laboratory tests and pharmaceuticals that could be potentially cosmetic, investigational or experimental or in need of medical necessity review criteria. Technologies selected for medical policy development include services that may be considered:

• A new procedure, medical device, medication, or therapeutic test that are of great interest to the public and provider communities
• Controversial treatment options for managing care
• Anticipated as high volume, high cost utilization
• Known or suspected overutilization or inappropriate usage
• Life-saving technologies
• Procedures previously designated as experimental or investigational that may be evolving into the standard of care
• Technology found to have a high potential for harm

Evidence Based Medicine

Managed Care Health Plans use a systematic evidence-based approach for the development of medical policies that includes a thorough review of the peer-reviewed published medical evidence. Sackett et al. have defined evidence-based medicine as “The conscientious, explicit, and judicious use of current evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.” The strength of the evidence regarding a medical technology is used to determine whether the service is safe and effective and the impact on patient net health outcomes. The strongest evidence is contained in a large randomized double-
blinded controlled clinical trial that compares the technology to standard treatment/testing. Other evidence may include the following publications in order of strength (strongest to weakest):

- Systematic review and meta-analysis
- Prospective cohort comparison studies
- Retrospective studies
- Large case series
- Small case series
- Case reports, opinion statements

There must be sufficient evidence from medical or scientific literature to identify the therapeutic value, the improvement or beneficial effect on health outcomes, or to establish the therapeutic advantages over established alternatives. Insufficient evidence may be defined as: evidence obtained from studies other than good quality randomized-control trials or minimally biased prospective cohort/comparison studies. Opinion statements, case studies, abstracts, and retrospective studies are not considered high quality evidence and are not usually sufficient for quality decision making.

**Research Tools**

Technology Assessment tools involve a critical appraisal of the published evidence concerning the safety, effectiveness, and clinical impact of a particular healthcare technology that may include a medical device, pharmaceutical or therapeutic intervention, diagnostic or screening test, or preventive strategy. Where applicable, the technology is compared with conventional care and other alternate or competing technologies. The goals of technology assessment tools are to facilitate evidence-based decision making, which then improves the quality and cost-effectiveness of healthcare. There are several technology assessment organizations that may be used to assess the strength of the evidence and determine whether a technology is safe and effective and improves health outcomes. The Blue Cross Blue Shield Technology Evaluation Center (TEC) Assessment Criteria use a specific evidence-based model to evaluate a technology and have been adopted by all of the Blue Cross Blue Shield plans. Technologies that do not meet all of the following five TEC criteria are considered investigational:

1. The technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

These TEC assessments offer a comprehensive evaluation of the clinical effectiveness and potential benefit of a given medical procedure, device, or drug and are developed by a multidisciplinary team of experts to help other Health Plans make informed healthcare decisions.

Other proprietary (available only to subscribers) technology assessment tools used by Health Plans to review evidence are the Hayes Knowledge Center and the ECRI Institute. The Hayes Knowledge Center is a resource that delivers independent, unbiased, and evidence-based analyses of new, emerging, and controversial medical technologies. The database includes Directory reports outlining the strength of the evidence with a Hayes rating system. This rating system (A-B-C-D), developed by Winifred S. Hayes, Inc., reflects the strength and direction of the evidence regarding a medical technology (procedure, test, device, biologic, drug, intervention, process, or program), including safety and efficacy, impact on health outcomes and patient management, indications for use, and patient selection criteria compared with the standard treatment/testing. Many Health Plans consider a topic rating of C or D as investigational. The ECRI Institute is an organization whose mission is to benefit patient care by promoting the highest standards of safety, quality, and cost-effectiveness in healthcare. ECRI offers research, publishing, education, and consultation on many health care topics that include comparative effectiveness, quality and outcomes of health technologies, drugs, and procedures to help Health Plans make informed decisions.

Additional resources for policy development include database searches (i.e. PubMed, Ovid, Embase, Cochrane reviews), statements from governmental regulatory agencies such as the Food and Drug Administration (FDA), Centers for Medicare and Medicaid Services (CMS), Agency for Healthcare Research & Quality (AHRQ), National Institute of Health (NIH) and the Center for Disease Control (CDC). Other research guidance is obtained from nationally accepted programs and such as the California Technology Assessment Forum (CTAF), the Institute for Clinical and Economic Review (ICER), the Institute for Clinical Systems Improvement (ICSI), and the National Institute for Health and Clinical Excellence (NICE) guidelines. Consideration is given to guideline statements from national medical professional specialty society associations (i.e. National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology, American Heart Association, etc.) and recommendations from medical specialists or professional experts obtained from independent review organizations. Many Health Plans also seek opinions from specialists within their provider network. Finally, federal and state law, contract language, including definitions, specific contract provisions and exclusions are reviewed carefully and are an important part the review process for the development of medical policy documents. If there is a federal or state law mandating coverage of a particular technology, the mandate supersedes any policy statement.

**Policy Development & Approval**

After the scientific evidence from the peer reviewed medical literature and information from all the applicable resources have been compiled, reviewed and outlined, the medical policy is drafted. Most medical policies follow a similar design template and include a summary description of the technology, FDA approval if applicable, a policy statement or recommendation that outlines whether the technology is investigational or medically necessary with review criteria points, a summary of the medical evidence, statements from professional society organizations, any applicable medical procedure and diagnosis codes (CPT, HCPCS and ICD codes) and resource references. The draft policy
then goes through a rigorous review and approval process that may include internal and external review by the same or similar specialists followed by presentation at a technology assessment or medical policy committee. The committee membership is usually comprised of medical directors (MD’s), pharmacy directors (PharmD’s), behavioral health medical directors (M.D.’s, PhD’s) and other experts who review and make the final decision and approval on the medical policies. After approval, medical policies may be distributed to the provider community via Health Plan newsletters, and/or posting on internal/external websites. Medical policies generally are re-evaluated and updated annually but may be reviewed prior to their scheduled review date if there is any new scientific evidence published that would change or impact the policy criteria.

**Conclusion**

Medical policy is based on a body of authoritative information obtained from peer-reviewed published medical literature, database searches, medical consensus entities, professional health care standards and guidelines, evidence from national medical organizations, state and federal government agencies and technology assessment research organizations. Policies identify experimental or medically necessary position, appropriate clinical application, efficacy, and safety and summarize research findings and medical consensus regarding the medical technology. Using the highest quality of scientific evidence ensures that the Health Plans’ membership receive safe and effective care that is appropriate and of therapeutic benefit with a positive impact on health outcomes. Medical policy development using the evidence based method create the foundation for informed clinical decision making and safeguard the quality of care for the patient and provider community.

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**References:**

When Did Technology Replace Bedside Patient Care?
Michelle Snyder, RN, MSN; Mark Hansen, RN, MSN, CMCN; Aimee DeChiara, RN, MSN; Jennifer Austin, RN, MSN, CCM

Summary

Fee-for-service (FFS) reimbursement based on productivity or patient quality is rapidly changing. With the implementation of the Affordable Care Act (ACA) and its related value-based payment models such as outcome-reimbursement or pay-for-performance, various providers and organizations need to be aware of the potential financial impact associated with futile attempts at reducing costs. These attempts include at-risk behavior associated with clinical decision-making, taking shortcuts, and assuming that expensive technologies prepare providers to deliver quality care, subjecting them to payment penalties as well as legal consequences as a result of careless and negligent acts.¹² Care begins with taking the time to know your patient. Technology should never supersede the hands-on interaction between the health care provider and the patient.

Key Points

- A study performed by the American Journal of Emergency Medicine uncovered 43 percent of emergency room physician’s time is spent entering information into a computer compared to 28 percent of the time with patients.⁷
- Physicians are not the only guilty party, The Trend Report found case managers are also spending less time patient facing. Case managers reported that the time spent in non-direct patient care activities increased from 34 percent in 2010, to 39 percent in 2012.⁸
- Inadequate or incompetent medical management increases the risk for unsafe discharges, increased readmission rates, increased financial burden including fines, and mortality.

The Adoption of Health Information Technology (HIT) and its implementation is to “enhance the quality and efficiency of care” while improving communications between multiple providers and their patients.³ The goal is to improve interactions between patients and their clinicians by providing a secure method of accessing health information. Efforts have been made to facilitate care coordination, however, from the patient’s point of view these efforts are often fragmented and more provider-centric versus patient-centric. One cannot discount the advantages of modern technologies as they do provide convenient access to lab, diagnostic and other test results.⁴ Are modern technologies being over utilized and are health care providers relying on HIT to provide cost effective care rather than hands on (bedside) assessments? Has modern health care diminished the ability to recognize professional and ethical obligations in physician and nurse-patient relationships? Consider these questions while you read the following case study.

Patient Scenario

Managed Care patient Jane Doe, age 62, is transferred by ambulance from a rural community hospital to a tertiary facility following a three week history of increasing memory decline, falls, lower extremity weakness, plegia, and new onset of bowel and bladder incontinence. Patient has a history of discectomy and lumbar fusion as well as recent falls with resultant hip fracture six months prior. Patient is accompanied by her adult daughter, a registered nurse, who provided full patient history to Emergency Room (ER) staff, Neurosurgeon, and consulting Nurse Practitioner. Magnetic Resonance Imaging (MRI) of the lumbar spine was obtained which revealed spinal stenosis. Following Neurosurgery consultation, it was determined that the patient’s symptoms did not correlate with the MRI results and patient is to be admitted for a full neurology workup. Full patient history is provided again to both the hospital and staff nurse by the patient’s daughter. Due to patient’s mental status, daughter provided hospital staff her personal information and requested to be contacted for questions or with any new information.

The following morning, the patient’s daughter was greeted by a Social Worker who explained her mom was cleared for discharge and could return home. This information was questioned by the daughter who then spoke to both the staff nurse and physician who wrote the order. The hospital advised that he reviewed the patient’s HIT and determined that the necessary Neurology testing could be performed on an outpatient basis. There was no medical necessity for Ms. Doe to remain inpatient. The Hospitalist confirmed that he had only discussed the patient with the previous Hospitalist by
Outcome

Following reports to the CMO and QM department, a thorough workup was provided including laboratory studies, lumbar puncture, Computed Tomography (CT), and additional MRI. Lumbar puncture revealed an elevated white blood count and additional MRI revealed an epidural abscess. IV antibiotics were immediately prescribed. Further MRI revealed a lesion in the spinal canal at the T4-5 level, and surgery was performed with preliminary pathology revealing spinal meningioma. Following surgery, patient was transferred to acute neurological rehabilitation at the same facility and started on Physical and Occupational Therapies. Following rigorous therapy, the patient regained complete function of her lower extremities and the ability to stand and walk without assistance.

Supporting research

One of the assumptions of HIT was that it would lead to more patient-centered care although some realize this is not happening. Phillips cites Abraham Verghese, M.D. who feels “this focus on technology has replaced meaningful direct-person interactions”. Studies confirm this as well. Goodman and Norbeck reference a study performed by Block et al. who discovered interns are spending more time with the computer than with their patients. Only 12 percent of their time is patient facing, while 40 percent is in front of the computer. Another study performed by the American Journal of Emergency Medicine uncovered 43 percent of emergency room physician’s time is spent entering information into a computer compared to the 28 percent of the time with patients. Physicians are not the only guilty party, The Trend Report found case managers are also spending less time patient facing. Case managers reported that the time spent in non-direct patient care activities increased from 34 percent in 2010, to 39 percent in 2012.

Solution

Bacigalupe and Askari feel a collaborative health movement advocating for integration of patient care is needed. This would include using “the patient’s family as an intrinsic piece in the health intervention, and in which the professionals and institutions work together with the patient”. Quality bedside nursing has seemingly declined and the unfortunate consequence is deterioration in the patient’s condition or compromised treatment plan. Coordination of care involves other health care professionals from various disciplines who all have crucial roles in planning for safe patient discharge. Quality of care is measured in terms of outcomes, the end results of care and treatment, or it is evaluated by how the care is evaluated by how the care is delivered. Achieving care plan objectives and meeting patient needs are essential to successful discharge planning and the ability for the patient to achieve optimal health recovery.

All healthcare professionals are expected to promote quality of care through efficient communications and accurate assessments. This demonstrates behavior of genuine patient care. There are issues that encumber delivery of care such as staffing shortages and time constraints, however, these factors should not impact patient care or allow crucial health information to be overlooked. The unfortunate outcome of inadequate or incompetent medical management increases the risk for unsafe discharges, increased readmission rates, increased financial burden including fines, and mortality.

In this scenario the hospitalist relied on HIT versus visiting the patient at the bedside. While this method was perceived as more time efficient, important physical and mental symptoms were neglected. These would have been apparent upon performing hands on physical assessment. Fortunately for this patient, her daughter was a nurse and was able to advocate for her and prevent an adverse outcome.

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Motivational Interviewing and Patient Interactions
Connie J. Riggs, BSN, MSM, RN, HIA/MHP, CMCN

Summary

Motivational Interviewing is a set of techniques used by a variety of practitioners in the healthcare setting. While the concept is multifaceted, the content of this article is as follows—definition, statistics, change stages, change talk examples, OARS details, engage/focus/evoke/plan model review, the Readiness Ruler review, and sample encounters. Additional resources for the healthcare professional have been provided on the last page.

Key Points

- With the OARS technique, patients can share their feelings, perspectives and other issues. OARS stands for open ended questions; affirmations; “reflective listening”; and “summarizing”.
- The healthcare professional must use affirmations that focus on something positive about the patient and the agreed upon plan of care.
- Reflective Listening keeps the healthcare professional focused on statements and issues the patient has shared. Reflection is used to decide what to focus on or ignore.
- Summarizing assists the healthcare professional and the patient to achieve better communication; there are several different types of summaries.

DEFINITION AND STATISTICS

What is Motivational Interviewing? The “lay definition” is “a collaborative conversation style for strengthening a person’s own motivation and commitment to change”. As of 2013, Motivational Interviewing has been initiated for “an estimated 3 million” known clients.

The basic fundamental elements include “establishing rapport”, “asking open-ended questions”, “affirming”, “change-related statements”, “eliciting recognition of the gap between current behavior and desired life goals”, “asking permission before providing information”, “responding to resistance without direct confrontation”, “encouraging the client’s self-efficacy for change”, and “developing an action plan to which the client is willing to commit”. It is used by multiple practitioners in “substance abuse, mental health, psychiatry, primary healthcare, nursing, supported employment, tobacco cessation & recovery, vocational rehabilitation, residential, housing, healthcare, and criminal justice” programs. It may also effectively be used in Case Management, Disease Management, and Chronic Care Management.

Stages of Change

Motivational Interviewing is a practice skill used by healthcare professionals to better communicate with their patients. However, if the patient is not ready to change, no change can occur. Commonly accepted models of change include the phases of pre-contemplation (the patient has no thoughts of change); contemplation (the patient is thinking about change and looking at the benefits of change); preparation (the patient is working on small changes, seeing what works); action (the patient is making changes); and maintenance (the patient is sustaining change). With all of the stages of change, there is always the chance of relapse.

Miller and Rollnick use the pneumonic DARNCATS to help recognize and reinforce change talk from the patient. “Preparatory change talk” is “DARN”, signifying the patient is preparing to make a change; “mobilizing change talk is “CATs”; they signal a movement(s) for the patient to change. Even though these are not all “…possible forms…” of change talk, the healthcare professional must be skilled in recognizing change talk from the patient, to be successful with patient outcomes.

The ‘D’ is the desire or wish to change; an example might be ‘I wish I could keep up with my grandchildren’. The ‘A’ is the ability to change; it is typified with statements such as ‘I could start walking every day to see if that helps’. The ‘R’ is the reason to change; the healthcare professional could ask the patient for the top three reasons to change. The patient might say ‘to feel better, keep up with my grandchildren, and be around for them for a while; I know at 350 pounds, it’s only a matter of time before I end up in the hospital with a heart attack or stroke’. The ‘N’ is the need to change, how important is it and why—‘I just don’t feel very good.
Examples of reflective statements include: “half of all their responses… are reflections”.

To focus on or ignore, what to “…emphasize or de-emphasize…”. Patient experience from a “…personal exploration…” aspect. On statements and issues the patient has shared; it enhances the “…parental…” , focusing on you and not the patient.

Such as ‘I’m proud of you’, but ‘I’ statements can sound almost especially with a house full of company’.

Have zero weight gain from last month—that must have been hard, you were able to walk 4 times this week—way to go!'; and 'you

Affirmations are statements and responses meant to about the experience?”; ‘how about your expectations?’; and ‘was current reflection to something from a past interaction.’

Closed-ended questions (yes/no or other single word response questions) will not be effective in making progress with treatment plans, as they limit responses the patient makes to you.

Samples of closed ended questions might be:

• ‘Are you feeling better?’
• ‘Did you make it to your October therapy appointment?’
• ‘Have you lost any weight?’

Samples of open ended questions might be:

• ‘Can you tell me more about how you are feeling…?’
• ‘You shared in our last visit that transportation was on issue. Could you help me to better understand that…?’
• ‘How can I help you with your weight loss goal?’

Affirmations are statements and responses meant to “…recognize and acknowledge that which is good…” and to “…support and encourage….”. But to accomplish this, the healthcare professional must listen and understand the patient, with the focus on the patient. Affirmations should focus on something positive about the patient and the agreed upon plan of care. Examples of statements which convey affirmation include—’you did a great job avoiding sweets this week, especially with eating out’; 'so, you were able to walk 4 times this week—way to go!’; and ‘you have zero weight gain from last month—that must have been hard, especially with a house full of company’.

Of note, some healthcare professionals may use ‘I’ statements such as ‘I’m proud of you’, but ‘I’ statements can sound almost “…parental…”, focusing on you and not the patient.

Reflective Listening keeps the healthcare professional focused on statements and issues the patient has shared; it enhances the patient experience from a “…personal exploration…” aspect. Reflection is used by the healthcare professional to decide what to focus on or ignore, what to “…emphasize or de-emphasize….”. Miller and Rollnick convey that “Counselors skillful in MI offer two to three reflections on average per question asked, and about half of all their responses… are reflections”.

Examples of reflective statements include:

• ‘You’re frustrated with your husband for bringing snacks into the house.’
• ‘You’re annoyed with yourself because you had no time to exercise this week.’

Summarizing assists the healthcare professional and the patient to achieve better communication; there are several different types of summaries. A “collecting” summary can be used with two or three items or topics shared by the patient. An example might be, “So, you’d like your asthma control over the next 6 months to be better. You’re getting on track with taking your medications, but want to understand more about use of your rescue inhaler. You also said you’d like to better understand your triggers. What else, as you see your health changing?” A “linking” summary connects the current reflection to something from a past interaction.

An example is ‘So, you felt mad because your daughter didn’t call you after your heart specialist appointment, like she didn’t care about you. If I recall, there was another time that your sister didn’t call you and you felt the same way.’ The “transitional summary” pulls “…together what seems important” or can signal “…a shift to something new”. An example would be ‘OK, so I have a couple of questions I need to ask before we can move forward. But, before I do that, let me see if I understand what you need help with today. You need some diabetic meal plans, and suggestions for healthy snacks. You’d also like to see a dietician and join a Senior Exercise program. Did I miss anything?’

Engage, Focus, Evoke, Plan

What other techniques can help you better interact with your patient? You can learn how to better engage, focus, evoke and plan with the patient. Engagement is “the degree to which someone feels like a comfortable and active participant in the consultation”. If a patient arrives for an appointment, or you are talking with the patient and they feel anxious, confused or frustrated, it is a challenge. However, engagement goes both ways—how does the culture of your organization drive engagement? In its simplest form, if engagement occurs, “the client returns…” so a “…working alliance…” is forged.

From Miller and Rollnick, Bordin, 1979, shares the following aspects of “positive engagement”:

1. “Establishment of a trusting and mutually respectful working relationship”;
2. “Agreement on treatment goals”; and
3. “Collaboration on mutually negotiated tasks to reach these goals”.

To increase engagement, asking questions such as, ‘what do you hope to achieve’?; ‘how important is it’?; do “you feel good about the experience”?; ‘how about your expectations’; and ‘was this helpful?’ may be useful.

Several strategies promote disengagement. They include:

• The “assessment trap”, asking many questions before establishing rapport with the patient—how many companies issue directives to make contact with the patient, then request their Case Managers to ask ten pages worth of assessment questions?
• The “expert trap”, having the prescriptive solutions when
“what is needed is personal change” (for the patient)^2

• The “premature focus trap”, trying to focus on treatment goals instead of really listening to the patient; for instance, if you are meeting a diabetic patient for follow up, but the patient has three school age children and no money for food, will the patient focus on what you have to say, or, their children’s needs?^2

• The “labelling trap”, calling the problem by name^2

• The “blaming trap”, the patient is overly concerned and wants to blame something or someone^2

• The “chat trap”, using too much “small talk” can demotivate the patient^2

Conversely, a patient might ask their own internal questions of the healthcare professional, such as ‘do I feel respected by you?’; ‘do I feel like I can trust you?;’ and ‘do I think there is open negotiation?’^2 Focusing means to actively listen to a patient and focus on what the patient wants to focus on—clarifying goals and direction for change. This can occur as a result of positive engagement and usually leads to agreement on a treatment plan. Evoking solicits the patient’s “motivations for change”, emphasizing the importance of the change and the confidence to undertake the change. The planning phase allows the healthcare professional and the patient to develop a plan that the patient is willing to implement—it ties the plan into a neat package. Remembering engaging, focusing, evoking and planning can allow you to build upon each step.

Readiness Ruler

An additional tool to use for patient interactions is the Readiness Ruler—this tool contains two scales to measure confidence and importance. For instance, a question to ask the patient would be ‘how confident are you that you can make the change?’ (On a scale of 1-10, 1 is low confidence, 10 high confidence); a second question would be ‘how important is the change to you?’ (On a scale of 1-10, 1 is low importance, 10 is high importance). This tool provides the healthcare professional with another opportunity to dialogue further with the patient by asking questions such as, ‘what makes you a 6 and not a 3?’ If the actual ruler is not available, you can simply draw a line on paper and have the patient indicate their rating. The Readiness Ruler may be ordered or downloaded from http://www.centerforebp.case.edu/resources/tools/readiness-ruler

Encounters

So, with the information you have been provided, let’s examine two encounters; you decide, as the healthcare professional, which one will start to promote optimal patient outcomes.

Encounter 1

Healthcare professional (HCP): Are you feeling better today?
Patient: Yes.
HCP: That’s good. Is your diet plan working?
Patient: No, not so good.

HCP: Are you taking your medications as directed?
Patient: Most of the time.
HCP: Are you exercising, like we talked about last time?
Patient: Yes, sometimes.

Will this encounter start to promote optimal patient care outcomes? Let’s take a look at the same encounter, but using Motivational Interviewing techniques.

Encounter 2

Healthcare professional (HCP): Hello, Ms. Jones—how are you?
Patient: Well, I have to say, I feel better than I did a month ago. After I decided to do something about my weight, I’m really starting to feel better.

HCP: Good for you; how do you feel better?
Patient: Well, I have more energy, I can walk a little now, and play with my grandkids in the backyard.
HCP: More energy can make you feel better! Tell me, if you would, what have you done to change how you eat?
Patient: Well, I cut way back on sweets; you know I love desserts. I’m also eating more salad and vegetables.
HCP: You’ve come a long way from when we talked 3 months ago; keep up the good work! What would you like to tackle next?
Patient: Well, I’d like to see if I can limit my desserts to once or twice a week. Is there anyone I can talk to about what I eat?
HCP: That sounds like a great next step. If you would like to talk to a dietician, there is one here in my office if you’d like to see her.
Patient: That would be good; how do I get that setup?
HCP: I can have my nurse get you scheduled.
Patient: OK; thanks.
HCP: How is that new medicine working for you?
Patient: It seems to be working well, but I don’t take it every day because of the cost. My sugars are down in the 140s.
HCP: That’s a lot better than 3 months ago when your numbers were consistently in the 170s. I have some samples of that medicine I can get for you.
Patient: Thank you.
HCP: Now, if you would, tell me about your physical activity, your walking.

Patient: Well, with more energy I feel like walking, so I go shopping about 3 times a week, either to the store or the mall.

HCP: That’s a good start. Did you ever consider walking regularly at the mall? Many people are mall walkers during the winter.

Patient: No, never really thought about it, but it sounds like something I could do now.

HCP: Do you want to try it?

Patient: Yes, I think I do.

HCP: What sounds doable?

Patient: Well, I could try to make one circle around the mall twice a week.

HCP: Sounds like a good plan. On a scale of 1-10, with 1 being low and 10 being very high, how confident are you that you can make the change?

Patient: I think about a ‘6’. Not sure I can get to the mall that often, but I’ll try.

HCP: Ok; let’s see how that goes. So, to summarize our plan so far, I’ll have the nurse get you scheduled with the dietician and get you some samples; you’re going to try and schedule yourself for mall walks. Anything else I can do for you today?

Patient: No, not today. Thank you; see you next time.

HCP: Thank you; take care.

So, will this encounter start to promote optimal patient care outcomes? If your response is ‘yes’, you’re on the right track.

To summarize, this review provided the definition of Motivational Interviewing, statistics, change stages, change talk examples, OARS details, engage/focus/evoke/plan model review, the Readiness Ruler review, and sample encounters. There are many techniques to use; additional resources are listed at the end of this article. Remember, it will take a while to get comfortable with Motivational Interviewing, but keep practicing—your patients won’t know if it’s correct technique or not, they just want to know someone cares enough about them to help them achieve their goals!

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References:


Additional Resources for the Healthcare Professional:

Nursing by the Numbers

How Nurses Stack Up

There were 2,711,500 registered nurses in the U.S. in 2012.

There’s expected to be almost 20% more nurses in the United States by 2022.

More than half of U.S. registered nurses have a bachelor’s degree or higher.

This percentage has increased by more than 5% in the last 10 years.

Two in five 19 to 39-year-old American nurses plan to obtain a master’s in nursing or a higher degree.

Nine out of ten U.S. registered nurses are female.

But there are three times more male registered nurses now than in 1970.
That means nursing will grow by nearly twice the rate of non-medical professions. This growth is comparable to many other medical professions, as seen in the graph.

Almost 2/3 of U.S. nurses work at state, local, and private hospitals.

- Hospitals: 61%
- Nursing Homes: 7%
- Doctors Offices: 7%
- Government: 6%
- Home Health: 6%
- Other: 13%
  (correctional facilities, schools, military)

AVERAGE WEEKLY HOURS WORKED BY MEDICAL PROFESSIONALS IN THE UNITED STATES

- Registered Nurse: 42 hours
- Nurses Aide: 40 hours
- X-ray Technician: 40 hours
- Doctor: 52 hours

=10 Hours

SOURCES:
- HTTP://WWW.BLS.GOV/NEWS.RELEASE/PDF/ECOPIRO.PDF
- HTTP://WWW.BLS.GOV/OOH/HEALTHCARE/RADIOLOGIC-TECHNOLOGISTS.HTM
- HTTP://WWW.BLS.GOV/OOH/HEALTHCARE/PHYSICIANS-AND-SURGEONS.HTM
- HTTP://WWW.BLS.GOV/OOH/HEALTHCARE/NURSE-ANESTHETISTS-NURSE-MIDWIVES-AND-NURSE-PRACTITIONERS.HTM
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- HTTP://WWW.AMMHEALTHCARE.COM.UPLOADEDFILES/MAINSITE/CONTENT/HEALTHCARE_INDSIGHTS/INDUSTRY_RESEARCH/2013_INDSURVEY.PDF
- HTTP://SCIENCE.EDUCATION.NIH.GOV/LIFEWORLDS/NSF/ALPHABETICAL-LIST/AIDE-NURSING+ORDERLIES+AND+ATTENDANTS?OPENDOCUMENT&SHOWTAB=ALL
- HTTP://EXPLORERECAREER.COM/EN/CAREER/20/RADIOLOGIC_TECHNOLOGIST
- HTTP://WWW.NURDVALLEITN.BLOG4HEALTH/2014/01/17/PRIMARY-CARE-SHORTAGE-OBAMACARE-PHYSICIAN-SALARY-SPECIALTY/
- HTTP://HPR.HRSA.GOV/HEALTHWORKFORCE/REPORTS/NURSING/WORKFORCE/NURSINGWORKFORCEFULLREPORT.PDF
- HTTP://WWW.CENSUS.GOV/PEOPLE/00FILES/MEN_IN_NURSING_OCCUPATIONS.PDF
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- HTTP://WWW.PATSCALE.COM/RESEARCH/US/JOB=REGISTERED_NURSE%2FDOCTOR/SALARY
- HTTP://WWW.PATSCALE.COM/RESEARCH/US/JOB= FAMILY_PHYSICIAN%2FDOCTOR/SALARY
- HTTP://WWW.PATSCALE.COM/RESEARCH/US/JOB=NURSE_MIDWIFE/SALARY

For every female doctor in the U.S., there are two male doctors.

Nine out of ten U.S. nurses are satisfied with their career in nursing.

Nearly 3/4 of American nurses would encourage others to choose this profession.

Less than half of all U.S. doctors say they would choose a career in medicine if they could start over.

TYPICAL ANNUAL SALARY RANGES FOR AMERICAN HEALTHCARE PROFESSIONALS*

- Nurses Aide: $17,941 - $30,835
- X-ray Technician: $21,452 - $59,648
- Registered Nurse: $42,223 - $82,020
- Midwife: $46,065 - $109,254
- Doctor: $96,509 - $206,282

*Figures correct at March 4, 2014

Maryville University
Case Management Alert:
Health Systems Taking Bold Steps to Narrow Networks, Partner with Single Post-Acute Providers

Dr. Josh Luke, FACHE

Summary

Care coordination programs in the ACA are here to stay. Health systems have new challenges of showing increased quality, shorter hold times, increased resources, enhanced communication between caretakers, improved access to doctors, nurses and resources and better outcomes, all of which are initiatives of care coordination. Skilled nursing facilities and other providers need to identify new revenue streams and strengthen resources through industry partnerships.

Key Points

• There are three major events in 2015 that symbolize the prioritization of care coordination.
  o An article in Modern Healthcare that focused on hospitals partnering with post-acute providers.
  o In May 2015, leading national health system University of California, San Francisco (UCSF) partnered with Hospice by the Bay in Northern California.
  o The University of California San Diego Health System partnership with Accent Care.

HANDS UP, THIS IS A STICK-UP! NOT REALLY, BUT THAT is how one provider described health systems asking post-acute providers for a share of their profits. Based on recent trends, this is likely to become the norm. While skilled nursing facilities (SNFs) and home health operators may be concerned about the trend, the truth is, post-acute operators should be jumping for joy if the local health system approaches them with this proposition (as opposed to their competition).

Why? Resources are shared, care delivery improves, efficiency increases and patients are happier all around. Sound familiar? It’s triple aim. This leads to higher volume, higher revenue, and even after splitting a portion of the profits, the post-acute provider is almost certain to find that their operating margin has increased.

The alternative? Well, you don’t really want to think about that. If you are not the chosen provider, it’s likely your SNF will become a custodial or long term care focused facility, or your home health will only be left with patients living in remote areas. Both are tough business propositions.

In 2015, the Center for Medicare and Medicaid Services (CMS) has gone to great lengths to send a clear message that the care coordination programs in the ACA are here to stay, and that hospitals who are not quick to reform will suffer significant financial consequences. While recent updates to the readmission penalty were modest, the changes to care coordination programs have been anything but. There are three major events to date in 2015 that symbolize this prioritization of care coordination.

On May 9, 2015, an article in Modern Healthcare titled Hospitals Select Preferred SNF’s to Improve Post Acute Outcomes, showcased hospitals nationwide that grew tired of waiting for patient choice and anti-steering regulations to be changed, had begun partnering with preferred post-acute providers. This essentially created narrow networks of post-acute providers around each hospital. The article also created a domino effect as hospital attorneys and compliance officers nationwide finally felt empowered to allow operators to get creative in narrowing post-acute networks by partnering with just a select few preferred SNF and home health providers in the region.

As an example, In May 2015, leading national health system University of California, San Francisco (UCSF) partnered with Hospice by the Bay in Northern California. While the announcement never stated that Hospice by the Bay would be the only or sole hospice provider for UCSF, but if Hospice by the Bay is the only hospice UCSF is partnering with and getting additional resources, then it goes unsaid that the intent of the entire announcement was to suggest that Hospice by the Bay will be UCSF’s sole partner in hospice. While this does not restrict a patient right to choice when being discharged from UCSF, it certainly creates an unlevel playing field when patients are presented the option that Hospice...
by the Bay is the only official partner of UCSF for hospice services.

And for those of you clinging to the fee-for-service free-for-all era... take a deep breath when I say this and make sure you are sitting down...its okay for hospitals to share that they have partnered with post-acute providers to improve the care continuum, even if it is just one provider per service line.

Perhaps the biggest sign of massive change on the horizon in 2015 as it pertains to coordinated care is that a major acute health system has now partnered with a post-acute provider in a revenue sharing arrangement. The significance of the University of California San Diego Health System partnership with Accent Care, a nationally known home health provider, is that the acute provider has chosen to partner with a post-acute provider in a revenue share arrangement. This will likely strike fear in the hearts of skilled nursing operators nationwide, but should not, as it is an inevitability that acute providers, traditionally rich in resources, will start turning to the providers it sends patients to, to share revenue as the acute revenue streams of the past dries up.

While many hospitals own home health services, it is rare to see a health system have an excellent home health division as the focus of health systems has always been on the higher revenue and higher margin acute services. Although that trend is certain to change in coming years as hospitals realize home-based care is the center of the new healthcare universe in an insurance model (coordinated care model) such as the ACA, the organization whose primary focus is on home care is the organization who will succeed by keeping costs down and achieving triple aim with its members.

The reality is that many hospitals cannot survive without creating new revenue streams. In order to partner with post-acute providers in a revenue share, hospitals must find creative ways to provide resources and bring value to the post-acute provider to justify the revenue share. What are the options for the post-acute provider? Pray that you are the provider of choice when the hospital comes calling. For skilled nursing operators, the option would be turning into a long term care only facility with lower reimbursement. For home health operators, the alternative to partnering with the health system seeking an exclusive arrangement is probably going out of business altogether.

While experienced hospital CEO’s are scared to death of fraud and abuse regulations that were a strong threat in the fee-for-service era, those days are clearly behind us. While some health systems are applying for fraud and abuse waivers, and others for innovation grants that allow narrow networks and profit sharing, others are simply tired of waiting and point directly to the care coordination incentives of the ACA to justify the time has long passed for revenue sharing partnerships.

Allow me to point out the obvious...health systems own skilled nursing facilities, home health service lines and hospice service lines. Health systems can also purchase each of these levels of service to absorb them into the system. Why then are they not permitted to purchase or partner in partial ownership?

Remember the intent of the rules when they were passed? To prevent abuse of the system by driving volume to a single hospital, post-acute provider or physician. Thus, the short answer to how to enter a partnership of this sort is to illustrate a value proposition for the partnership that is independent of volume increases. Volume will undoubtedly increase when the health system re-programs its care delivery to improve the continuum. More importantly, the health systems challenge in partnering is simply to show increased quality, shorter hold times, increased resources, enhanced communication between caretakers, improved access to doctors, nurses and resources and ultimately, better outcomes. Those things are all desired outcomes of recent care coordination initiatives.

2015 has brought dramatic change and clarity to the Federal Government’s expectations for the national delivery system to transform to a value based model sooner, rather than later. It is time to transform, partner and most importantly identify new revenue streams to replace the old as they diminish. It is a tough pill to swallow for experienced hospital executives, but the time has come.

Dr. Josh Luke, FACHE is widely regarded as a leading healthcare futurist, veteran hospital CEO and Founder of the National Readmission Prevention Collaborative, National ACO & Bundled Payment Collaborative, and National Bundled Payment Collaborative. He also is the author of ACHE’s top selling management book of 2015, Readmission Prevention: Solutions Across the Provider Continuum, and serves as Adjunct Faculty at the USC Sol Price School of Public Policy and as National Advisor, Strategic Transformation for the Health Dimensions Group.

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- Foundation Medicine, Inc.
- Gilead Sciences, Inc.
- Hill-Rom
- Home Instead Senior Care®
- Medicaid Matters Talk Show
- Morgan Consulting Resources, Inc.
- NextLevel Health Partners
- Purdue Pharma L.P.
- SeniorBridge®
- Tandem™ Diabetes Care
- Uroplasty, Inc.
Impact of the ACA on Patients with Cancer and Oncology Practices
Sheryl A. Riley, RN, OCN, CMCN

Summary
The Affordable Care Act (ACA) was created to provide patients access to the medicines and services they need, especially for the sickest among us but from what I have uncovered, at least in cancer care, this might not be the case.

Key Points
- In a recent article, published on June 11, 2014 by Pharmaceutical Research and Manufacturers of America (PhRMA), it was reported that a significant out-of-pocket burden is being placed on patients with serious illnesses by the majority of health plans in the ACA Exchanges.¹
- Many patients have no idea what they purchased on the exchange and therefore are overwhelmed when sitting with one of their social workers or financial advisors to learn about the cost of their individual treatment and what their plan covers or does not cover.
- A study by Avalere Health found that up to 90 percent of the ACA plans will force cancer patients to cover half the cost of new drugs until they hit the out-of-pocket maximum.
- There is a concern that some patients will give up as to not to burden their families with debt, and some speculate that this might have been the plan all along.

THE AFFORDABLE CARE ACT (ACA) WAS CREATED BY the government to provide patients access to affordable medicines and services they need, “especially for the sickest among us,”¹ but from what I have uncovered, at least in cancer care this may not be the case.

Before the ACA, the US Department of Health & Human Services, the Centers for Medicare & Medicaid Services, and other federal agencies gathered data from many healthcare market resources and experts; they focused on what was not working well in our current system. The goal was to improve the care and quality of services for all Americans and create a better system that will:
- Make healthcare affordable
- Assist with premium payments based on income
- Not deny care for preexisting conditions
- Have no lifetime maximum
- Expand services to all Americans who do not currently have healthcare.

I am not a fan of the ACA, because I believe that we, the consumers, and the free market can create a better system without government intervention. I also lack confidence in the federal government in managing healthcare based on the way they have managed our veterans and those in active military service. If that system is any example of what is in store for the American people with the ACA, then we should all be concerned. That being said, I decided to begin my research about the ACA with an open mind, hoping to find that I was wrong, and that patients and providers were benefiting from the new system.

High Cost Burden on Patients
I searched the Internet for articles regarding the ACA and all stakeholders. I looked for insight from thought leaders in managed care, employers, physician practices, patient foundations and support groups, and patients and their families, by interviewing medical directors, healthcare providers, cancer support foundation leaders, practice managers, and patients.

A 2014 report from the Pharmaceutical Research and Manufacturers of America (PhRMA) claims that a significant out-of-pocket burden is being placed on patients with serious illnesses by the majority of health plans participating in the exchanges created by the ACA.¹ This, in part, is a result of requiring particularly high cost-sharing for all medicines (in at least 1 category) for specific conditions. This cost burden limits patients’ access to needed medicines and leaves many patients with nowhere to turn, which can negatively affect their health outcomes and even their lives.¹

In the same study, data revealed that in 7 of 19 classes of therapies for serious illnesses, such as cancer, HIV/AIDS, autoimmune diseases, and bipolar disorder, more than 20% of Silver health plans require coinsurance of ≥40% for all drugs in those classes.¹ Similarly, in 10 of the 19 selected drug classes, ≥20% of Silver plans require coinsurance of ≥30% for those drugs.¹

Furthermore, more than 60% of Silver plans place all covered medications in their formulary in the highest tier, including drugs for multiple sclerosis, rheumatoid arthritis, Crohn’s disease, and certain types of cancer.¹ Responding to these findings, Carl Schmid, Deputy Executive Director, the AIDS Institute, said, “We want the Affordable Care Act (ACA) to work, including for people living with HIV/AIDS,” but “shifting the cost of medications to patients, by some plans, is not only blatant discrimination, but it can lead to poorer health outcomes since beneficiaries will not be able to afford and access their life-saving medications.”¹

John J. Castellani, President and Chief Executive Officer of
PhRMA also commented on the findings, saying, “The Exchanges were meant to provide patients access to the medicines they need, especially for the sickest among us. Yet this report paints a very different picture, one in which many Americans still find themselves unable to access the care they desperately need due to high out of pocket costs.”

Virginia T. Ladd, RT, President and Executive Director, American Autoimmune Related Diseases Association, noted that “putting treatments out of reach of autoimmune patients with life-changing and life-threatening diseases makes no sense.” Ms Ladd added, “This approach not only results in poorer outcomes, but eventually causes a significantly higher price tag for medical costs due to preventable disability and the loss of quality of life for the patients.”

Community Cancer Centers
Patients and their families are under incredible stress when diagnosed with cancer (or other serious illnesses), and the added burden of increased medical cost, on top of insurance cost, can bring them to their knees. When interviewing patients, as well as practice managers and their staff who deal with patients and their families daily, the common themes of concern involved costs, copays, coinsurance, and “How do I pay for this and not burden my family?”

I spoke with Anne Slam, Practice Manager at the Eastern Connecticut Hematology and Oncology Associate practice, which has approximately 50 employees (5 physicians and 3 advance practice registered nurses) and sees approximately 150 to 200 patients daily. Ms Slam joined the practice in 1990 and has been the administrator for approximately 20 years. She is also involved with our Connecticut Oncology Association, and is a member of the Community Oncology Alliance Administrators’ Network. Through the years, she has served on many committees and has been a reimbursement consultant, speaking throughout Connecticut.

Ms. Slam discovered that many of the patients in her cancer practice have no idea what type of health plan they selected through the exchanges, and are therefore overwhelmed when they discuss with social workers or financial advisors their treatment costs and the details of their plan coverage. In addition, they have to deal with the out-of-pocket expenses and copays.

Ms. Slam noted that because of the uncertainly surrounding coverage under the ACA, the practice staff has to call each plan to understand what services are covered for each individual patient before the patient begins treatment. This back and forth is time-consuming and has caused her practice to hire more staff, just to be able to provide this service. In addition, many plans do not get back to them in a timely manner, which could delay treatment for the patient, which is a huge area of concern according to Ms. Slam. She assured me that her practice was not delaying treatment for the patient, which is a huge area of concern according to Ms. Slam. She assured me that her practice was not delaying treatment for patients, and that their oncologists will not change the way they practice because of these changes introduced by the ACA. Rather, they will move forward in good faith so that patients can obtain their lifesaving chemotherapy without delay.

Quality of Cancer Care
My concern is that not all providers will emulate Ms. Slam’s practice, and if that happens, the quality of care for patients with cancer will rapidly deteriorate. The time between diagnosis and treatment is crucial in the fight against cancer, and any delay can reduce the patient’s chances for remission and possible cure. To better understand the patient experience under the ACA, I interviewed patients and spoke with 2 of the leading cancer support foundations that work with patients with cancer locally, regionally, and nationally—the Cancer Support Community and CancerCare.

After speaking with several patients with cancer, I was disappointed to hear that they were dealing with increased costs of copayments and coinsurance, and were denied access to some of the top oncology centers in the country, many of which do not participate in the ACA.

In addition, patients who completed treatment and their disease was in remission were not always given survivorship care and guidance; that is, the majority of patients with cancer who complete treatment want to get back to their normal lives but are not provided with the tools to do so, including information about exercise, nutrition, and a follow-up schedule.

One patient in particular completed a physically debilitating treatment and did not know where to go or what to do to feel whole again, and “not like a cancer patient.” With no guidance from her doctor or covered benefits from her health plan, she explored physical therapy, for which she paid out of pocket. In only a few short weeks of physical therapy, and with the encouragement of her therapist, she was on her way back to work, and her “precancer life.” Survivorship care needs to be part of the value-based care championed by the ACA.

The high cost of treatment is clearly a concern for patients with cancer. One patient reported not having follow-up scans and appointments, because of an inability to pay the copays; another patient reported taking medication every other day instead of daily because of the cost. Yet another patient with breast cancer stated that her monthly cost for radiation therapy was $27,000. Many patients asked, “How can I focus on healing and getting better when I have so many bills, debt, and am afraid I cannot afford what could possibly save me?”

In my discussions with medical directors, they echoed much of what I had heard from others and added other thoughts. The quality of care was their utmost concern, and they are hoping that delays in care and patient choice for the type of treatment do not take a wrong turn.

Patient Support Organizations
In my quest to better understand how the ACA is affecting patients and their care, I contacted Vicki Kennedy, LCSW, Vice President of Program Development and Delivery, Cancer Support Community, which provides patient education, assistance, and support to patients with cancer across the United States.

Commenting briefly about the ACA, Ms. Kennedy noted that “anecdotally, we have patients and caregivers calling our Cancer Support Helpline who have referenced that without the ACA they would not be receiving cancer treatment, but they are in need of further assistance with co-pays, transportation, living expenses, mental health issues, among other services. The cost of care penetrates deep into a family who has to make choices everyday—‘fill my prescription, or buy groceries; pay my co-pay, or my heating bill, etc.’”

Ms. Kennedy added, “Many families are getting by and express gratitude that they now have insurance, but their worry doesn’t end there. I sense that while the government has tried to fix part of the system (access to insurance), there is still much work to be done in controlling cost, fraud, high malpractice costs, and all the other essential parts that plague our healthcare system. I confess I tend to talk more cancer patients who are relieved that ACA exists than those who are angered by it.”

She directed me to her colleague, Linda House, MSM, BSN, RN, President of the Cancer Support Community. Ms. House commented that many of the issues discussed here are not necessarily a direct result of the ACA, but rather the result
of the implementation of ACA and the way insurance plans have structured benefit designs. She focused on the pros of the ACA and is taking a wait-and-see approach to the cons. She says that the pros of the ACA include no lifetime limits, improved coverage of clinical trials, and removal of the preexisting condition clause. She did note that there has been an increase in cost, copays, out-of-pocket expenses, and provider redirection, but she hesitated to blame that on the ACA. Rather, she said that more patients are in need of services and support, patient coverage appears to be less inclusive of drugs and services, and if patients do have the covered services, the out-of-pocket costs and copays are so high that they may opt out of receiving treatment altogether. She encourages oncology practice managers to review the Cancer Insurance Checklist available at www.cancerinsurancechecklist.org, which may be a helpful resource.

Ms. House also informed me of the Cancer Support Community’s latest white paper study and patient–provider video that are focused on the patient experience.2,3 The video is filled with heart-wrenching interviews with patients who recount how the system has repeatedly let them down, cost them more money, and does not allow them to receive treatment at some of the top cancer centers or to see the most reputable oncologists (not all of these issues can be directly ascribed to the ACA).3 In the video, providers discuss how some patients choose not to have expensive treatments, because they do not want to overburden their families.3

I also spoke with Patricia J. Goldsmith, Chief Executive Officer of CancerCare. CancerCare is another incredible organization that does amazing work to support, educate, and care for patients with cancer and their families. According to Ms. Goldsmith, the organization has witnessed an increase in demand for support services, such as transportation, babysitting, cleaning services, and financial support; however, she finds it difficult to attribute this increase in demand for services solely to the ACA. She believes that more time is needed to fully assess the impact of the ACA, and hopes that patients will begin to see improved coverage and enhanced benefits.

The ACA and Cancer Care

Robert Goldberg, PhD, Vice President and Co-Founder, Center for Medicine in the Public Interest, stated in a 2013 article that “millions of Americans with cancer and other chronic illnesses will wind up paying more for lifesaving care, if they can get it all.”4 He noted that in an effort to keep cost under control, the White House had created a cut-rate HMO. The low-profit margins have forced insurers to downsize the number of physicians and hospitals in their networks, and to slash what they cover for out-of-network treatment.4

Dr. Goldberg notes that some health plans do not cover the majority of leading cancer centers and the top physicians, which can be devastating for some patients. All across the country, renowned cancer centers, such as New York’s Memorial Sloan Kettering Cancer Center, are excluded by the largest health plans.4 California’s Cedars-Sinai Cancer Center has been excluded from all ACA plans, and only a few plans include the Mayo Clinic. In Washington state, the largest exchange plans exclude world class cancer care for children, such as the Seattle Cancer Care Alliance.4 Although patients can receive care from out-of-network entities, they will typically have to pay the full price for these services.

The article cites an example of a cancer survivor whose monthly premium was approximately 50% of his monthly take-home pay; however, he did not mind, because his plan covered all his treatment—more than $350,000—and allowed him to see the top specialists, including physicians from the Mayo Clinic, with an out-of-pocket expense of only $4500.4 However, the introduction of the ACA forced the insurer to stop that old plan, which, in turn, forced the patient into a plan that fits the ACA rules. As a result, that patient:

- Can no longer keep his Mayo Clinic physician (who kept him alive for 7 years)
- Will have to pay $26,000 out of pocket
- Will pay more for drugs.

Dr. Goldberg notes that the ACA also skimps on drug coverage, severely limiting the types of therapies current plans cover. Many pre-ACA plans just charged a copay of approximately $50 to $70 monthly for cancer drugs. Under the current ACA, thousands of patients with cancer have to pay more than $2500 monthly for drugs. On average, these plans cover only 10 targeted therapies, and insurers do not have to add new breakthrough therapies until 2016.4

Dr. Goldberg referred to 2 studies by Avalere Health that further underlined the financial burden patients may experience under the ACA. One study showed that up to 90% of ACA plans will force patients with cancer to cover 50% of the cost of new drugs until they hit their out-of-pocket maximum; conversely, only 29% of non-ACA, employer-based plans do so. The second study showed that patients are 4 times more likely to stop using innovative therapies if they have to pay $500 or more.4 According to Dr. Goldberg, the concern is that some patients will sacrifice receiving appropriate treatment in an effort to not burden their families with financial debt.

I cannot say for certain that the ACA has made oncology care better or worse, but I can certainly say that it appears there are more patients with financial needs than before and this is troubling. Also, it is important to note that just having insurance does not guarantee people the care they need by the doctors or hospitals they want. Patients with cancer and others with serious illnesses are struggling just to stay alive; if the ACA has truly been created to make healthcare affordable “for the sickest among us,” then I am giving it a “needs improvement” grade. I will continue to monitor the impact of the ACA on cancer care, and hope it improves during the next 12 months.

Sheryl A. Riley, RN, OCN, CMCN is the Director of Clinical Services for Caris Health.

References:
Utilization management (UM) positions fall under many different names and can include a wide scope of combined responsibilities, but their essential goals are the same. Balancing quality, risk, and cost concerns.

**Key Points**

- Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called ‘Utilization Review’.

**Definition of Utilization Management**

Healthcare professionals involved in the Utilization Management process have the responsibility of balancing quality, risk, and cost concerns. The goal of UM is to maintain the quality and efficiency of healthcare delivery by treating patients at the appropriate level of care, coordinating all available healthcare benefits, and ensuring the least costly but most effective treatment plan. This is chiefly accomplished by validating true medical necessity using nationally accepted clinical practice guidelines, such as InterQual or Milliman standards.

Imagine going to the ER for a broken leg and the doctor orders a chest X-ray and a blood panel to check your cholesterol levels. The Utilization Review nurse at the hospital should flag that there is often a lot of cross over between the roles and departments. Depending on the size and structure of the organization, you might find Care Management and Utilization Management functions under the same department; sometimes it is in the Case Management Department, less frequently it falls under Quality Management. Occasionally it will be a combination function position, where it is the same person doing both CM and UM. Here we will focus on the different titles, terms, and functional roles that fall under the Utilization Management umbrella, regardless of how it looks on an organizational chart.

“Utilization management (UM) is the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called ‘Utilization Review’.”

- URAC (Utilization Review Accreditation Commission)

What’s in a Name? - Utilization Management

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request (if no one else catches it) as lacking in medical necessity. If the hospital somehow does not catch the error, they can be sure the health insurance company will, and the claim for reimbursement will be denied. Now if that same ER doctor had ordered a leg X-ray and crutches, the Utilization Management personnel at every step would have approved the process and authorized the claim, based on established guidelines. The decades-long trend of deliberately or mistakenly ordering unneeded tests and procedures has been identified as one of the key factors in the extreme rise in healthcare costs in America, and Utilization Review nurses are on the front lines of this struggle.

For Utilization Review professionals, the various job titles and functional terms relate to when the action is taken in the patient’s continuum of care. Meaning at what stage was the treatment reviewed for medical necessity; either before, during, or after it was provided. When then review is conducted AFTER the treatment has been provided, it is called Retrospective Review, as it looks back at the usage. This is one of the most common forms of review for health insurance companies, particularly for emergency procedures where treatment cannot wait for prior health plan approval.

When the review happens DURING patient treatment, it is called Concurrent Review. These happen during active management of a condition, be it inpatient or ongoing outpatient care. The focus of Concurrent Review is to ensure that the patient is getting the right care in a timely and cost-effective way. In a health plan setting, this is a more fast-paced and demanding role requiring experienced and high-energy nurses due to the need for rapid processing of cases. Because Concurrent Review is used to decrease the amount of time you spend in the hospital, the first Concurrent Review in the hospital often determines a discharge plan.

One of the best known forms of Utilization Review occurs BEFORE the patient treatment is even scheduled, and it could be called Prospective Review but is better known as Prior-Authorization or Precertification. These might include non-emergency hospitalizations, outpatient surgery, skilled nursing and rehabilitation services, home care services, and some durable medical equipment. These treatments are typically not urgent or emergency matters and can wait the time needed for both provider and payer to play it safe and be on common terms of what will be authorized for reimbursement.

We could add more confusion and continue to muddy the waters by discussing what happens when a claim is denied and a member files an appeal on the case, or a grievance against the health plan. Since it is the Utilization Review process which initiates the process by issuing a denial of the claim, they do have a hand in denials and appeals, but most commonly appeals and grievance issues are handled by the Quality Management department.

As stated initially, CareNational specializes in recruitment and career search consultation in these specialized areas, but we do not perform these functions ourselves. So how did we do? Did we accurately identify the most common job titles related to these functions and duties? Did we miss anything or get anything wrong? Please let us know! What titles does your organization use? What terms have you seen throughout your career? We want to hear from the experts: that’s you!

CareNational® is a leading national medical management support organization specializing in talent recruitment services for some of America’s leading health plans, TPA’s, providers and third-party medical management companies.

References:

AAMCN Would Like to Welcome Our New Members!

Elizabeth Anderson, RN, BSN, CRRN, Student
Rachel Arcuri, BSN, RN, Service Coordinator, United Healthcare
Alicia Atchison, BSN
Tiffany Denton Bachman, MSN, RN, Service Coordinator, United Healthcare
Chrisopher L. Bailey, Assistant Vice President, Nexus Medical Consulting
Jen Balzano, RN
Colleen Berding
Stephanie Berman, RN, CCM, Horizon Blue Cross Blue Shield of New Jersey
Sharon Berry, BSN, Clinical Consultant, Premera Blue Cross
Bethany B. Boice, LPN, Quality Blue Educator, Blue Cross Blue Shield of LA
Maryanne Bourque, RN, Managed Utilization Management, Nemours/AI Du Pont Hospital for Children
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Ginille Brown, Family Nurse Practitioner, LA Care Health Plan
Suzanne Brown, BSN, President/Consultant, Suzanne Brown Care Management
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Laura Bucciarelli, Senior Director of Managed Care
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