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Cybersecurity for Clinical Managed Care Professionals

Jeff Frater, RN, BSN

Summary

Healthcare data breaches are dominating news headlines, with 2015 seeing an exponential increase in the number of Americans' whose records were exposed. Now, more so than ever, cybersecurity is of paramount importance for everyone in healthcare, clinicians included. Traditionally, cybersecurity was viewed as the responsibility of the information technology (IT) department, with management and leadership of other departments having little responsibility or understanding of security controls. However, due to the substantial increase in volume of electronic health data, the number of clinical applications, a history of poorly secured systems, the penalties and costs of healthcare data breaches and the alarming frequency and pervasiveness of protected health information (PHI) breaches, the non-information technology healthcare professionals no longer can afford to “leave it to IT”. This article will explore the recent history of health-related data breaches, the most common types of health data breaches, and help identify responsibilities for non-IT professionals in ensuring appropriate cybersecurity measures are applied and adhered to.

Key Points

- Cybersecurity has gone from what most clinical or business operational professionals once considered an afterthought, or the responsibility of the IT department, to a topic that must be at the forefront of thought for every clinical professional at all times.
- The vulnerable nature of healthcare data and infrastructure and now the risks to the safety of the public should serve as a wake-up call for everyone in the healthcare industry.
- Protected health information security attacks are more personal and harder to fix compared to credit card information theft.

CYBERSECURITY: WHAT IS IT AND WHY DOES IT Matter to the Health Professional?

The National Initiative for Cybersecurity Careers and Studies defines cybersecurity as, “The activity or process, ability or capability, or state whereby information and communications systems and the information contained therein are protected from and/or defended against damage, unauthorized use or modification, or exploitation.” Thus, these are the methods that are used to keep protected and sensitive information from people who should not have access. This protection goes beyond merely preventing the unauthorized view or stealing of data, there is also the risk that data will become corrupted or be destroyed. Each of these damages are unique in their impact and consequence, as well as presenting varying methods and strategies to detect, and better yet prevent, inappropriate activity that is occurring with regards to protected health information (PHI).

Today, the types of systems requiring cybersecurity measures go far beyond the once suitable solutions of data warehouses living behind varying degrees of firewalls and other electronic security measures. The explosion of interconnectivity that began with the Internet has expanded with cloud hosting, Wi-Fi access points, mobile messaging, tracking devices and ultimately to the “Internet of Things” (IoT), which enhances data interoperability, but also presents multiple points of potential entry or data exposure. Cybersecurity has gone from what most clinical or business operational professionals once considered an afterthought, or the responsibility of the IT department, to a topic that must be at the forefront of thought for every clinical professional at all times. The threats are real and breaches are increasing at alarming rates.

This article will explore the scope, history, types of data breaches and methods of effective security control. Ultimately, the goal is to help the non-IT clinical professional have a basic understanding of cybersecurity measures while having a clear understanding of what their responsibilities are in regards to cybersecurity.

Scope of Problem

Unfortunately, most security control practices, in addition to providing some level of safeguard, also impose an administrative or workflow efficiency burden on departments and individuals. In the comprehensive text, Handbook of Information Security Management, Krause and Tipton acknowledge: “Because certain computer security controls inhibit productivity, security is typically a compromise toward which security practitioners, system users, and system operations and administrative personnel work to achieve a satisfactory balance between security and
productivity." Unfortunately, due to the frequency and severity of cyberattacks, the pendulum swings towards the security controls with less priority placed on the impact to efficiency. The leaders who best understand the threats and the rationales for controls not only are best equipped to lead the departments in best practice, but are in the forefront in identifying creative methods to maximize efficiency while maintaining strong security practices.

Health-related security breaches from 2010 to 2015: The pace and size of security breaches have increased substantially in recent years. Consumers became painfully aware of the vulnerability of their data in 2014 when Target announced it had been breached and 40 million payment card numbers were stolen. But in 2015, healthcare stole the data breach limelight from retail with an exponential increase in the number of Americans impacted. In the time span from 2010 – 2015 the total number of American’s whose PHI was breached was a staggering 154 million. This represents nearly 48% of the U.S. population.

The Anthem breach alone resulted in nearly 80 million records being exposed, but even without Anthem the total number of individuals whose health records were compromised or stolen equaled 34 million, over twice the number affected in any of the four preceding years. (Infographic: Lives Impacted by Health Data Breaches)

In addition to the dramatic increase in the volume of people affected by healthcare data breaches in 2015, the nature of the stolen information was inherently more personal than the type of information typically comprised in retail breaches. The Target breach of 2014 included the names, mailing addresses and phone numbers of 40 million customers. Some customers’ credit card numbers, expiration dates, and PIN numbers were also accessed. Consider this in contrast to the data stolen in the 2015 Anthem breach, which included: names, dates of birth, Social Security Numbers, healthcare identification numbers, home addresses, email addresses and employment information, such as income. The very nature of healthcare data is much more intimate, and as discussed later in this article, makes it inherently more valuable to cyber thieves and criminals.

As alarming as those stories are, at the time this article was written, the latest cyberattacks on healthcare organizations involves malicious ransomware that has infected hospitals’ electronic medical record, order entry, registration and email systems. The creators of the ransomware demand payment to turn off the blocking software and allow the hospital access to its electronic systems. Meanwhile, the hospital has been turning patients away, resorting to paper processes and the return of telephonic lab results and jammed fax machines. The risk to patients for harm is very real. Clearly the criminals have continued to find new and increasingly frightening methods of using the vulnerabilities in healthcare’s IT systems to extract financial gain – and they don’t care who is hurt in the process. Industry experts fear it is only a matter of time until the cyber criminals infect implanted devices with ransomware thus holding the patients’ life hostage.

The increasing volume of healthcare data breaches places the highest priority on the race to implement secure electronic systems. The vulnerable nature of healthcare data and infrastructure and now the risks to the safety of the public should serve as a wake-up call for everyone in the healthcare industry. This article will provide the non-information technology healthcare professional an awareness of their role in protecting the safety and sanctity of electronic healthcare data. The cybersecurity world increasingly recognizes that while technical safeguards are imperative, human behavior still represents the weakest link in security programs and requires a culture of security and diligence to enforce security controls.

Historical Perspective: Cyberattacks

Understanding the history and evolution in the style of cyberattacks helps the clinical professional to understand the size of the threat and by recognizing the trend in cyberattacks be less likely to be victimized by an attack.

Late 1980’s and Early 1990’s: The internet’s first worm virus, dubbed the Morris Worm, after its creator, Robert Morris, was
released in 1988, setting up the fledgling internet to face a new dynamic in the early 1990’s. The Morris Worm was a DoS style (denial of service) type of malware. As this was early in the Internet history, it did not have a significant economic or social impact. Organizations affected began to recognize some of the potential disruption and developedCERTs (Computerized Emergency Response Teams). The primary focus was on the creation of a coordinated response to attacks and incidents.

**Late 1990’s:** The rise of mini-software program viruses, such as the “I Love You” virus that was embedded in email attachments were the standouts of the late 1990’s. When a user attempted to view or download an infected attachment, the software was activated. In the event of the “I Love You” virus, the software was programmed to overwrite random files on the local machine, then access the email address book of the user who had just opened it and email a copy of itself to everyone in the user’s address book, with a subject line of “I Love You”. This resulted in widespread impact on corporate email systems, as they were inundated with automated inbound and outbound emails. These early cybersecurity threats and attacks were focused more on creating havoc than any apparent financial gain. During this time, organizations began to invest in anti-virus technology and began enhancing their access controls (e.g. password policies).

**The 2000’s:** After the turn of the century, cyberattacks involving serial hacking and credit card theft became much more organized and sophisticated. Of particular interest was credit card information. From 2005 to 2007, a criminal ring gained access to retailer TJ Maxx’s record keeping systems repeatedly over the two-year period, stealing an estimated 45.7 million payment card numbers. Since these types of breaches involved regulated data (credit card numbers), TJ Maxx was required to report it to the authorities. This necessitated ever-increasing levels of response: defense (firewalls) and responses that extended beyond mitigating damage to the organization, but also working with affected parties (clients/customers). Arguably the largest impact of such breaches was that organizations began to recognize the value of data encryption.

**After 2010:** Increasingly sophisticated, increasingly simplistic tends to be the theme post-2010 when it comes to cyberattacks. The more recent attacks dominating news headlines (Target in 2014 and Anthem in 2015) represent both an advance, and a regression, in terms of the sophistication of the attacks.

In the Target attack, hackers used a vulnerability in one of Target’s vendor’s systems to gain access to the retailers’ transaction system. They were able to apply a software that captured payment card number information at the point of sale (PoS). This allowed the number to be captured and stolen before it was recorded, and encrypted, in Target’s record keeping system and represented a level of sophistication and coordination that was previously unprecedented.

The Anthem attack represented hacking methods that were almost at the opposite end of the spectrum of sophistication. In this situation, it is believed the attackers used social engineering to gain access to Anthem’s system. Rather than using sophisticated electronic and technical hacking strategies, the attackers tricked Anthem system users into providing access credentials, such as usernames and passwords.

**Present Day:** Ransomware continues to rise in prominence. As described previously, in February of 2016, Presbyterian Hollywood Medical Center was offline for over a week with its electronic health record (EHR) systems locked by malware described as ransomware. This software locked the hospital’s electronic data systems and impacted all hospital operations. Initial reports indicated the hackers were demanding a $3.6 million ransom to unlock the system. While the hospital settled for far less, with the success of this attack, experts are predicting that ransomware will become increasingly frequent this year.

In fact, experts are predicting that 2016 will result in far greater reliance on social engineering-style attacks to gain access to healthcare IT systems.

**Attacks and Breaches**

It is important for clinical staff to be familiar with the types of threats and attacks that hackers and thieves use. The more knowledgeable users of health IT are with the types of attacks, the more likely they are to recognize an attempted attack and avoid falling victim. Cybersecurity experts identify the following list as the most likely and frequent attacks to be alert for in 2016:

- **Phishing.** An attempt to acquire sensitive information such as usernames, passwords, and credit card details (and sometimes, indirectly, money), often for malicious reasons, by masquerading as a trustworthy entity in an electronic communication.
- **Malvertising.** An attack that delivers its malware by disguising itself as an online advertisement.
- **Ransomware.** A type of malicious software designed to block access to a computer system until a sum of money is paid.
- **Denial of Service Attacks.** An attempt to make a machine or network resource unavailable to its intended users, such as to temporarily or indefinitely interrupt or suspend services of a host connected to the Internet.
- **Drive-by downloads.** The unintentional download of a virus or malicious software (malware) onto your computer or mobile device. A drive-by download will usually take advantage of (or “exploit”) a browser, app, or operating system that is out of date and has a security flaw.
- **Man-in-the-middle attacks.** An attack where the attacker secretly relays and possibly alters the communication between two parties who believe they are directly communicating with each other.
- **Scareware.** Malicious computer programs designed to trick a user into buying and downloading unnecessary and potentially dangerous software, such as fake antivirus protection.
- **Password attacks.** One of the oldest tricks in the book, hackers use software that test combinations of commonly used passwords (e.g. “password”) to find one that works and grants access.
- **Software vulnerabilities.** Circumstances when software glitches or weaknesses are discovered and allow unauthorized access.
- **SQL injections.** A code injection technique used to attack data-driven applications, in which malicious SQL statements are inserted into an entry field for execution (e.g. to dump the database contents to the attacker).
Physical controls are those security controls established to provide an acceptable level of protection. Technical controls are defined as, “The use of safeguards incorporated into computer hardware, operations or applications software.” In other words, technical controls are embedded, or applied to the software and data warehouses to prevent, detect and correct unauthorized access. The most common technical controls are passwords, role based security, firewalls and antivirus software. Many users are likely familiar with the concepts of audit trails and activity tracking software or functionality. More advanced technical controls include intrusion detection systems and data encryption strategies.

Administrative controls are defined as, “Management constraints, operational procedures, accountability procedures, and supplemental administrative controls established to provide an acceptable level of protection for computing resources.” Essentially, administrative controls are the rules and processes that are created to guide the human use of information systems and sensitive data to enable, enhance and augment the physical and technical controls. Examples of administrative controls include security awareness training for all staff, separation of duties, procedures for terminating employees, risk assessments etc.

Security controls are generally grouped into three categories: physical controls, technical controls and administrative controls. When reviewing the trends of reported data breaches to HHS, there is a clear trend away from ‘lost hardware’ to ‘stealing’, but all data breaches must be guarded against.

Physical controls are those security measures that manifest in the physical realm. Doors and walls represent the most simplistic of physical controls. Of course the physical controls also include, locks, guards, badges and alarms. While security cameras are becoming more common, other advanced physical security controls might not be as familiar.

Technical controls: Technical controls are defined as, “The use of safeguards incorporated into computer hardware, operations or applications software.” In other words, technical controls are embedded, or applied to the software and data warehouses to prevent, detect and correct unauthorized access. The most common technical controls are passwords, role based security, firewalls and antivirus software. Many users are likely familiar with the concepts of audit trails and activity tracking software or functionality. More advanced technical controls include intrusion detection systems and data encryption strategies.

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Breaches: While some of the cyberattacks described above could result in a data breach, they are not one in the same. A data breach is defined as, “an incident in which sensitive, protected or confidential data has potentially been viewed, stolen or used by an individual unauthorized to do so. Data breaches may involve PHI, personally identifiable information (PII), trade secrets or intellectual property.” Data breaches not only occur when cyber thieves use electronic hacking or social engineering phishing to gain inappropriate access to data, they also occur when employees share data inappropriately or lose devices that contain electronic sensitive data.

When reviewing the trends of reported data breaches to HHS, there is a clear trend away from ‘lost hardware’ to ‘stealing’, but all data breaches must be guarded against.

Security Controls: Clinical professionals and leaders need to be familiar with typical security control mechanisms to ensure they are in compliance. Staff who understand the rationale for a control measure are less likely to attempt to bypass the control or use other shortcuts that might result in weakened cyber and health data security. Security controls are generally grouped into three categories: physical controls, technical controls and administrative controls.

Physical Controls: Physical controls are those security measures that manifest in the physical realm. Doors and walls represent the most simplistic of physical controls. Of course the physical controls also include, locks, guards, badges and alarms. While security cameras are becoming more common, other advanced physical security controls might not be as familiar.

Double door systems (man traps) and biometric access (e.g. fingerprint or iris scan) controls represent advanced physical security features that might be employed at a large or sophisticated data storage facility. Most advanced data hosting centers go further to include site selection (assessing for risk of environmental threats (e.g. flooding or tornado) but also avoiding terrorist targets or geographic locations that are prone to significant criminal activity.

Technical Controls: Technical controls are defined as, “The use of safeguards incorporated into computer hardware, operations or applications software.” In other words, technical controls are embedded, or applied to the software and data warehouses to prevent, detect and correct unauthorized access. The most common technical controls are passwords, role based security, firewalls and antivirus software. Many users are likely familiar with the concepts of audit trails and activity tracking software or functionality. More advanced technical controls include intrusion detection systems and data encryption strategies.

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Why Healthcare Data?

It’s worth noting the transition of the types of attacks and breaches as described in the history section. Early hackers were often more malicious than seeking monetary gain. The worms and viruses of the 90’s often would corrupt a computer’s hard drive or create volumes of email traffic that would impede network performance. These attacks were destructive and annoying, but lacked the financial motivation of the breaches that followed in the 2000’s and today.

The attacks on retailers like TJ Maxx and Target focused on pay card information. Credit card numbers, pin numbers, CVV codes, etc. This data obviously has a certain allure to the hacker, as the financial data can be used to conduct fraudulent purchases.

The question arises though, given the significant volume and increase in the healthcare data breaches, why is it that healthcare data is so desirable? Some experts indicate that healthcare data is 10 times more valuable on the black market than the credit card data exploited in the retail attacks.

First, note that when credit card information is stolen and used to make fraudulent purchases, the number is only good until either the individual or the credit card issuer recognizes fraudulent activity. In many cases that may be limited to one purchase.

In contrast, PHI (which, as noted previously, is far more intimate) allows more easily for identity theft. In contrast with a credit card number, which may only be good for one purchase, identity thieves are often able to run significant credit debt (even filing fraudulent U.S. tax returns) before the individual notices the fraudulent activity.

PHI that includes health insurance, benefits and coverage information can often be used to fraudulently receive or pay for healthcare services, including filling prescriptions (think of the prescription narcotic epidemic).

Health Care Data and National Security

Furthermore, there are national security implications if the health data includes transactional information, such as diagnosis and procedure codes; which could enable hostile foreign powers to gain insights into geographic or population health trends and create targeted biological attacks.

Finally, similar to ransomware, there is a strong likelihood if certain diagnoses or procedures of individuals were known they could lead to cases where an individual may be compromised (either financially, or perhaps give unauthorized access to systems, state security secrets, etc.) by the hacker threatening to expose embarrassing or otherwise sensitive health information.

Humans Are the Weakest Link

A recent article in the Harvard Business Review explored the incredible information security practices of the Pentagon. As one might imagine, the number of information systems containing critical information about the strength and vulnerabilities of the United States military forces is substantial and the allure to foreign governments and rogue cyber criminals unfathomable. In fact, the U.S. military reports daily attacks and intrusion attempts on its information systems numbering in the hundreds of thousands, yet the Pentagon’s record of data intrusions is remarkably low.

The Pentagon has recognized that the most vulnerable element of their information security strategy are the humans that...
must access and utilize the information systems. The success of the Pentagon’s cybersecurity program can best be illustrated by the concept of a high-reliability organization, or HRO. HROs are organizations that succeed in avoiding catastrophes in an environment for which the outcome of failure is catastrophic, think airlines, air-traffic control and the space program. The military has many such programs. These principles represent the strategy that clinical leaders must employ to ensure that intrusions and data breaches are not the result of their departments. These principles are:

- **Integrity**: Every member of the team understands the potential outcome of mistakes and takes ownership of the mistake/outcome.
- **Depth of Knowledge**: People who understand how systems work are more readily able to recognize when it is not behaving correctly.
- **Procedural compliance**: Staff are expected to know the operational procedures (security controls) and not to take shortcuts or other actions that might seem easier and more efficient, but ultimately place the system at risk.
- **Forceful backup**: Even highly trained and experienced staff members always have others observing for errors and all members of the team are empowered to call out discrepancies.
- **A questioning attitude**: Simply put, a culture that encourages “listening to internal alarm bells, searching for causes and taking corrective action” means problems will be stopped and negative outcomes minimized.
- **Formality in communication**: In other words, communication methods are clearly established and communications that reduce attention to the critical nature of the operation are discouraged.

The Pentagon’s conclusions were that nearly every data incident and cybersecurity breach was a result of a breakdown of one of these six principles. In order to further confirm that it is the human users of health IT that create vulnerabilities and require the attention of clinical leaders in healthcare settings, is the determination that the Anthem and Premera breaches were a result of a phishing attacks. The hackers likely set up fake domains that mimicked the corporate sites (e.g. www.premera.com instead of www.premera.com) and sent emails to employees to get them to visit the sites (thinking they were official sites set up by their employer) and by completing forms at those sites, shared detailed information with the hackers. Proper and effective security awareness training may have helped the employees to recognize the phishing attempt email and avoid victimization.

**Final Thoughts: Clinical Leaders and Cybersecurity**
Ultimately, due to the value of health information, and the increased vulnerability of health IT systems, clinical professionals must be hyper-vigilant and aware of the threats, attack methods and how to comply with security controls and maintain best practice cyber security habits.

Clinical leaders have an enhanced responsibility to ensure the staff and departments they lead adhere to security practices by:

- Understanding of common and emerging cyberattack methods
- Understanding of their organization’s security controls
- Maintaining personal habits of best practice in security controls
- Fostering a culture of respect for and willing embrace of security controls
- Vigilance for suspicious activities in regards to information systems and sensitive data
- Rigorously enforcing adherence to security controls and policies

Regardless of what elaborate technical solutions are put into place, incident after incident confirms that humans represent the weakest link in the security control net and are frequently exploited. It is the responsibility of every clinical leader to remain educated on the threats and maintain strict adherence to organizational policy and personal best practice. Clinical leaders have a duty to ensure staff members attend required training and abide by the policies and procedures that are put into place.

As with each new innovation throughout history, new challenges and threats will arise – and the rapid advancement of health IT is no exception. In addition to finding health IT solutions that provide the efficiency support along with robust technical security controls, vigilance, knowledge and adherence to best practices are key to ensure your organization and the data of the lives covered remain secure.

Jeff Frater, RN, BSN is the Director of Partner Development and Privacy Officer at TCS Healthcare Technologies.

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Keep Fit: How One Health Plan is Addressing the Issue of Childhood Obesity

Jenny M. Rowlands, MPH, CHES, Janet Treadwell, RN, PhD, CMCN, Donaji Stelzig, MPH, CHES, CHWI

Summary

Childhood obesity is a national epidemic, which led Texas Children’s Health Plan (TCHP) to create a program called Keep Fit in the Greater Houston area of Texas. This program has seen positive behavior changes in self-reported logs such as a decreased consumption of sugary beverages and reduced daily screen time, through nutrition education and providing physical activity opportunities. Positive increases were also seen in increased physical activity, fruit, and vegetable consumption. TCHP plans to continue the program and add more behavioral health and interactive media components in the future to increase member engagement and impact.

Key Points

- Short-term program objectives:
  a. Knowledge increase in basic nutrition topics
  b. Behavior change and adoption of healthy lifestyle changes as seen through self-reported, weekly logs of sugary drink consumption, screen time, physical activity, fruit, and vegetable consumption
  c. Increased knowledge of community resources
- Long-term program objectives:
  a. Healthy lifestyle choices become routine for participants of the program
  b. Reduction in body mass index percentile
  c. Improved quality of life through reducing risk of obesity-related co-morbidities

THE CENTER FOR DISEASE CONTROL AND PREVENTION (CDC) states that as of 2011-2012 National Health and Nutrition Examination Survey (NHANES), 12.7 million children and adolescents ages two to nineteen years old were obese. In the same NHANES survey, 17.7 percent of six to eleven year olds and 20.5 percent of 12-19 year olds were obese. Obesity is defined as having a body mass index (BMI) at or above the 95th percentile according to gender specific and age appropriate growth charts. Numerous factors influence the risk potential of an obesity diagnosis including race, socio-economic status, adult head of household’s education level, and family history. The prevalence of obesity is greater among Hispanic and African American children and adolescents, with nearly one in five being obese. A CDC morbidity and mortality study concluded that in families where the adult head of household had lower levels of education, their children had higher rates of obesity, compared to adults with higher levels of education. Additionally, the higher a family’s income, the lower the prevalence of obesity, which is seen among families of preschoolers whose families are within 185 percent of the income-to-poverty ratio. Research shows serious physiological consequences of childhood overweight or obesity that include an earlier onset of puberty, premature death later in life, liver disease, diabetes, dyslipidemia, and high blood pressure, to name a few. Childhood obesity is not only a leading public health problem in the United States but also a significant issue in the state of Texas. As of 2011, 19.1 percent of children 10-17 years old were diagnosed with obesity, giving Texas the tenth highest obesity prevalence rate in the nation.

Texas Children’s Health Plan (TCHP) is located in Houston, Texas and was founded by Texas Children’s Hospital in 1996. It was the country’s first ever health maintenance organization created just for children. As a managed care organization, they offer a large network of primary care doctors, specialists, and hospitals to more than 380,000 health plan members. Membership composition consists of 55.2 percent Hispanic, 18.7 percent African American, 12.7 percent Caucasian, 10.6 percent other ethnic groups, and 2.8 percent Asian/Pacific Islander. Medicaid STAR and Children’s Health Insurance Plan (CHIP) products are available to qualifying children and pregnant women in Harris County and 19 surrounding counties in Southeast Texas through TCHP. Within the health plan, a case management department exists to help educate, coordinate, support, and assist members with chronic and complex medical diagnoses. This department functions telephonically with members and offers an opt-in...
program for members who agree to receive education, coaching, and coordination through a monthly follow up.

The need for an internal weight management program surfaced as primary care physicians requested support and referral options for health plan members diagnosed with obesity. In response, the case management department created the Keep Fit program to reach members ages 10 and 18 on the plan diagnosed with obesity. A registered dietitian and a certified health education specialist developed the curriculum based on the most recent information on nutrition education and weight management. Topics outlined the curriculum include My Plate (a tool created by the United States Department of Agriculture), portion sizes, serving sizes, healthy snacks, drinks, portion control, how to read nutrition labels, screen time, goal setting, and how to overcome barriers. The Keep Fit program launched in 2007 and as a seven-week program with the goal to empower families to self-manage their physical activity and healthy food choices. Since that time, the schedule has evolved in order to better meet member’s needs, gather adequate data, and maintain consistent attendance. For two years, the program was shortened to three-week sessions. As of 2015, the program meets every two weeks over an eight-week period. This allows more time for behavior changes to be observed on weekly logs and more time to monitor any changes in height, weight, and body mass index (BMI).

Methods

Members are identified and invited to attend the Keep Fit Program based on diagnosis in claims data of abnormal weight gain, pediatric body mass index percentile greater than the 95th percentile, and obesity. The pediatric BMI percentile is used for children ages two to twenty because of their constant growth and development, and is interpreted in relation to other children of the same gender and age. Keep Fit is a value-added service, meaning the health plan funds this program and can set criteria on participation requirements. Members 10 to 18 years old are invited to the program via mailed postcards, an e-mail, member newsletter, health plan website, or by calling member services. Members are required to attend with at least one parent or adult over the age of 18, and the entire family is encouraged to participate.

Health Educators staff the Keep Fit classes and a personal trainer or fitness instructor often teaches the physical activity portion. Education is delivered and reinforced with handouts in both English and Spanish, since 55.2 percent of plan membership is Hispanic. The program takes place on Saturdays at community sites for three hours on weeks one and four, and two hours on weeks two and three. Weeks one and four are longer due to paperwork and measurements taken. Community locations are chosen by overlaying areas with highest membership with areas that have the highest prevalence of obesity. A different location is used for each session in order to make the program as accessible as possible. Fitness activities change weekly, but have included a soccer clinic, boot camp, kickball, basketball, flag football, tennis, obstacle courses, youth aerobics, and dancing. Guided grocery store tours and cooking classes are often incorporated into the program curricula for further education about food choices and smart shopping tips. At the conclusion of the program, three members receive grand prizes based on highest weight loss percentage, participation, and effort. Prizes are valued at $30 or more and are related to physical activity.

Data

The main goal of the Keep Fit program is to provide empowering, motivating, and interactive education to bring about positive behavior change, which is measured through questionnaires, surveys, and self-reported logs. A nine-item knowledge pre-test and post-test is distributed the first and final weeks for families to complete, along with a satisfaction survey completed by the parents on the final week. Children complete a six-question readiness survey on their first week to assess attitudes toward physical activity and nutrition. Questions have a blank comments box and a five point Likert scale of answer choices. During the program, participants complete weekly logs tracking their intake of fruits and vegetables, sugary drinks, physical activity, and screen time (which includes television, computer, and video games). These self-reported logs provide a quantitative measurement so that staff can easily identify behavior patterns. Height and weight are measured on the first and last week of the program to calculate each participant’s BMI percentile.

Data from 242 logs was collected and results averaged in five behavior areas to see if there was in fact a behavior change in participants. The following figures show the percentage of participants over 18 sessions (years 2009 to 2015) who have made positive behavior change in five areas: fruit and vegetable consumption, sugary drink consumption, physical activity, and screen time.

Results

Figure 1. Percent improvement by session for decreased sugary drinks

Figure 1 shows that in 17 sessions, over 40 percent of participants decreased their sugary drink consumption from the first week to the final week. (Sugary drinks are considered any soft drink, juice, Kool-Aid, and/or sports drinks.)

Figure 2. Percent improvement by session for decrease in screen time

www.aamcn.org | Vol. 3, No. 2 | Journal of Managed Care Nursing 11
Figure 2 shows that in 16 sessions, over 40 percent of participants decreased their screen time from week one to the final week. (Any time spent in front of a computer, video game, or television counted towards the weekly screen time amount.)

Figure 3. Percent improvement by session for fruit intake

![Figure 3](image)

Figure 3 depicts that in 11 sessions, over 40 percent of participants increased their intake of fruit from the beginning of the program to the end.

Figure 4. Percent improvement by session for vegetable intake

![Figure 4](image)

Figure 4 displays that in 13 sessions, over 46 percent of participants increased their vegetable intake from the beginning of the program to the end.

Figure 5. Percent improvement by session for physical activity increase

![Figure 5](image)

Figure 5 shows that in 11 sessions, more than 42 percent of participants increased their physical activity from the beginning of the program to the end.

Conclusion

From 2009-2015, the Keep Fit program has been successful in reaching members in their local communities and seeing a positive behavior change in its participants. The greatest improvements seen in weekly logs were decreased consumption of sugary drinks and screen time. At the most, four out of five attendees consumed less juice, soft drinks, sports drinks, and Kool-Aid as the program progressed. The average percentage decrease in sugary drinks across all 18 sessions was 59 percent. Four out of five attendees made behavior changes to reduce time spent watching television, playing video games, and on the computer. On average, participants across all 18 sessions decreased screen time by 61 percent. Behavior change in areas of fruit and vegetable consumption and physical activity appear the most difficult for participants. On average, 41 percent of participants increased physical activity, 45 percent increased fruit consumption and 46 percent increased vegetable consumption. This data highlights areas of opportunity for more interactive, practical, and educational interventions to better engage the targeted population in making better food choices and increasing physical activity.

The Keep Fit program has established community partnerships that have included Houston Parks and Recreation, Dance Houston, YMCA, a local kid’s gym, and H-E-B, a local food retailer. Program partners have provided space to host the program, and led participants in physical activity, cooking demonstrations, and guided grocery store tours. Not only do these partnerships increase member engagement, but they also connect members with local resources. The goal is for the basics of living a healthy lifestyle to be replicable for families once they complete the program. Members are allowed to repeat the program, but ultimately they are encouraged to make changes in their home environments and daily routines in order to establish healthy lifestyles for their families.

Future direction for the Keep Fit program includes incorporating media, adding a behavioral health component to the curriculum, and creating text reminders for healthy tips to participants. In January of 2015, the program piloted a media component where participants submitted two “selfie” photos. Members were asked to submit a photo of them making a healthy meal at home one week, and submit a photo of them being active another week. Participants were excited to show the staff what they had accomplished in the time between meetings, and nearly every participant submitted a photo. Establishing “selfies” as a part of the curriculum encouraged families to take what they have learned and put it into action. Additionally, tracking behavior on an app instead of a handwritten log could appeal more to the adolescent population we are trying to reach. Research on the use of mobile applications to measure childhood obesity-related outcomes is limited, but does appear to boost motivation and goal-setting behaviors among users.10

Adding a behavioral component to the Keep Fit curriculum would allow the program to more holistically address the complex needs of participants. Research show that a child who is overweight or obese is more likely to experience anxiety11, body dissatisfaction12, low self-esteem13, bullying or teasing, depression14, and disordered eating habits15. Topics to address
in Keep Fit in the future could include self-esteem, body image, motivation, how to deal with temptations and goal setting.

Utilization of text reminders could assist in increasing engagement and help foster greater behavior change among participants. A randomized controlled trial done by Price et al. studied the impact of interactive text messaging on behavior change related to childhood obesity. After a yearlong intervention of one to two text messages sent each week, nearly two-thirds of participants responded to 75 percent or more of the questions they were sent. A pilot study on the use of text messaging for obesity-related behaviors found that there was significantly greater adherence to self-monitoring in children receiving text messaging with reply abilities, than children keeping paper diaries or not monitoring behaviors at all. A text message campaign may be a good avenue to invest in as a health plan since it is a common means of communication and nearly every kind of phone has basic texting abilities.

In the years to come, TCHP will continue implementing and improving the Keep Fit program for its membership. Since data shows positive behavior change in the majority of program participants, it is apparent that families are learning how to incorporate physical activity and healthy food choices into their lifestyle. There are still thousands of members to reach with this program, but TCHP looks forward to the challenge of empowering families through education in the years to come.

Jenny M. Rowlands, MPH, CHES, Health Education Specialist at Texas Children’s Health Plan in Houston, Texas. A graduate of Baylor University, she has been a health educator at Texas Children’s Health Plan for the last two years. Her public health interests include public health, behavioral change, and disaster relief particularly among women and children.

Janet Treadwell, RN, PhD, CMCN, is Director of Care Coordination at Texas Children’s Health Plan where she leads programs directed to improving the health of vulnerable populations through multiple program venues. Mrs. Treadwell’s interest areas are in improving methods of identification and engagement to effectively reach individuals in need.

Donaji Stelzig, MPH, CHES, CHWI, is a Health Education Specialist at Texas Children’s Health Plan. Currently pursuing a doctoral degree in Public Health at Texas A&M University, she has worked for both the Harris Health System and M.D. Anderson Cancer Center to educate communities and promote health. Her interests include Hispanic/Latino health, prevention and population health.

References:

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Post-traumatic Stress and its Effects on Emergency Nurses

C. Patricia Mazzotta, RN, BScN, MScN

Summary

Emergency nurses continuously encounter human suffering, loss of life and witness traumatic incidents that have implications on them as frontline nurses. One of the posed risks that emergency nurses face is Post-Traumatic Stress Disorder (PTSD). The fifth edition of the Diagnostic and Statistical Manual of Health Disorders (DSM-5), recognizes PTSD, unfortunately, the label of ‘first responders’ and identification of ‘police officers,’ hinders recognizing that emergency/trauma nurses also suffer from the effects of PTSD. The literature suggests there is a significant gap in addressing the issue of PTSD within nursing because the research focus is centered with other disciplines such as social workers, first responders, correctional workers, and psychologists. Thus, education is crucial in assisting emergency nurses in recognizing the signs of PTSD but more importantly, seeking assistance before they are forced to leave the profession.

Key Points

• Post-traumatic Stress Disorder is defined as “the disturbance, regardless of its trigger, cause, that causes clinical significant distress, or impairment in the individual’s social interactions, capacity to work or other important areas of functioning.”
• Using the label of ‘first responders’ hinders the acknowledgement that emergency/trauma nurses also suffer from devastating effects of repeated exposure to human suffering and traumatic events.
• Minimal education, resources, and support systems are in place within organizations to assist emergency/trauma nurses cope with daily stressors of working in emergency departments.

I watch the tears fall of those who stand by.
I see their despair tearing them apart inside.
I feel so helpless as I watch at their side.
Trying to give hope, as my feelings I hide…2

DURING CRISIS AND DISASTERS, EMERGENCY/TRAUMA nurses are required to respond to critical situations and deal with traumatic events. Without a doubt, emergency departments (EDs) are chaotic, unforgiving, and relentless; the physical, psychological, and emotional demands placed on nurses are crippling the profession.12 With advances in technology, higher patient acuity, and working within the confines of budget cuts, the burden of quality patient care falls to nurses working the front line. Although emergency/trauma nurses are not considered first responders, emergency nurses are at risk of developing Post-Traumatic Stress Disorder (PTSD) simply because of the constant exposure to human suffering, high client mortality, morbidity, and traumatic events often leads PTSD.6

The purpose of this paper is to understand the phenomena of PTSD on emergency/trauma nurses. Hence, the use of labels such as ‘first responders’ hinders recognition of PTSD in emergency nurses.

Post-traumatic Stress Disorder is defined as “the disturbance, regardless of its trigger, cause, that causes clinical significant distress, or impairment in the individual’s social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs, or alcohol.”13 The fifth edition of the Diagnostic and Statistical Manual of Health Disorders (DSM-5) released in May 2013, clearly illuminates that recurrent exposure to traumatic events meet the criteria for PTSD and apply this to police officers and
first responders.\textsuperscript{1} Despite the literature demonstrating the effects of compassion fatigue, secondary traumatic stress and PTSD has on emergency nurses, the DSM-5 does not specifically include nurses in their discussion. However, the American Psychiatric Association (APA) acknowledges recurrent exposure to traumatic events does cause significant distress to first responders.\textsuperscript{1} I would argue that using the label of ‘first responders’ hinders the acknowledgement that emergency/trauma nurses also suffer from devastating effects of repeated exposure to human suffering and traumatic events. In addition, because the DSM-5 specifically identifies police officers and first responders in PTSD criteria, it neglects other occupations such as emergency/trauma nurses, who suffer similarly to first responders. Often people take it for granted that emergency/trauma nurses are immune to the effects of human suffering and traumatic experiences, because it is the assumption that nursing is founded on caring and compassion and thus, it is an expectation of the profession.\textsuperscript{12} Unfortunately, this is not the case for most emergency/trauma nurses.

Figley (1995) suggests that when nurses are traumatized because of witnessing repeated human suffering and traumatic events, they may become desensitized and have difficulty coping with their job.\textsuperscript{3} Hence, the emergency nurse risks “becoming a victim by extension”, because they forget to care for themselves and each other. Admittedly, nurses often do not take time to regroup or voice their concerns after witnessing an emotionally charged event, thus by putting their client’s needs before their own, nurses are increasingly vulnerable to emotional distress, physiological symptoms such as headaches, digestive problems, insomnia, fatigue and cardiac problems.\textsuperscript{7} Another confounding element that places emergency nurses at risk of PTSD is because most of the literature is conceptual or anecdotal and empirical studies have focused on social workers, first responders’ correctional workers and psychologists.\textsuperscript{4} Although research exists on the phenomena of PTSD, in healthcare there is a deficiency in regards to support programs, medical treatment, and education for emergency nurses. Tatano Beck (2011) conducted a systematic review of secondary traumatic stress finding only five studies that solely focused on nurses.\textsuperscript{11} Despite evidence demonstrating the effects of human suffering and traumatic events on first responders and emergency nurses, a gap in literature, education, and treatment exists. Ultimately, then, my goal is to demonstrate that despite a vast amount of literature on PTSD, emergency/trauma nurses continue to be in jeopardy because they are not aware of the risk of PTSD. I will point out that for over 17 years I worked in critical care and emergency/trauma units and not once did I receive education on the phenomena of PTSD. Many will probably argue that resources are already in place for nurses to deal with the stressors and coping strategies for witnessing continued human suffering in emergency/trauma units because organizations make debriefing accessible to all health professionals after critical incidents. However, most emergency/trauma nurses would agree that often debriefing does not occur immediately following a critical incident or traumatic event because of high workload, lack of available resources, and the acuity of emergency departments.\textsuperscript{8}

Short (2012) suggests, “an important role of leadership is debriefing the caregiver after contact with trauma.”\textsuperscript{10} After I witnessed prolonged aggressive resuscitation, I understood the need to share my feelings of distress, turmoil, and failure, with someone who would understand what I was experiencing. However, the reality in my experience was not immediate debriefing rather, it was suggested I contact the Employee Assistance Program (EAP) made available to me through my health benefits. Lombardo and Eyre (2011) recognize EAP is a valuable resource available in the workplace. Although I can appreciate having EAP services available to me, it was not a realistic option because often the wait time for an appointment was not conducive to my needs and I did not receive time off to attend a counseling session that I needed immediately following a traumatic event.\textsuperscript{7} Riley (2014) retells her ordeal of experiencing a traumatic event when working as an emergency/trauma nurse. While working in the trauma room of the ED she was assigned to care for a “police officer who had been shot in the face at close range.” She relived the experience numerous times, to the point of debilitation, more disheartening was knowing that the “police officers would be offered support and that the nurses would be offered nothing.” This traumatic experience and lack of support made her leave the profession. She admits that the EAP “did not have the resources required to deal with what was happening to me” and it would be years later when she would be diagnosed with PTSD. Emergency/trauma nurses are expected to work extended shifts under complex and hectic circumstances without the psychological first aid needed to survive the stressors of our profession.\textsuperscript{9} Hooper, Craig, Janvrin, Wetsel and Reimels (2010) suggest the cost of not having interventions in place to assist emergency nurses leads to “increased absenteeism, turnover, decreased performance and difficulty in recruiting and retaining” these specialized nurses.\textsuperscript{5}

In conclusion, the reality is that emergency/trauma nurses endure the effects of witnessing human suffering and traumatic events; the literature suggests that these nurses are at high risk of developing PTSD. However, minimal education, resources, and support systems are in place within organizations to assist emergency/trauma nurses cope with daily stressors of working in emergency departments. If we are to prevent PTSD in emergency/trauma nurses, it is imperative that nurses become aware of how to recognize symptoms of PTSD and when to seek assistance to prevent them from leaving the profession. Education is of utmost importance, for the retention of these specialized nurses.

C. Patricia Mazzotta, RN, BScN, MScN is a Professor of Nursing at Centennial College and a PhD Nursing Student at the University of Victoria.

References:

5. Hooper, C., Craig, J., Janvrin, D. R., Wetsel, M. A., &
The Road to Medical Management Leadership: The Basics

CareNational® Healthcare Services, LLC

Summary

If you are interested in moving into a nurse management position, there are important factors that employers will consider before selecting a candidate. These factors include time spent at a place of employment, references, education, technological knowledge and mentorship. Employers consider all parts of your resume, but strengthening these areas can give you the edge over other candidates.

Key Points

• Longevity in employment with reputable organizations will look better on your resume when applying for management positions than if you have hopped from job-to-job and only stayed at your place of employment for short periods.
• Providing solid references at the earliest stages of consideration demonstrates your ability to be proactive and that you have had a solid work past that allows others to brag about your value.
• Candidates for management can strengthen their resume with advanced education and certification specific to their profession.
• Dedicated case managers, utilization review personnel, and quality improvement staff seek every opportunity to refine their use of programs such as Microsoft Word, Excel, PowerPoint, and Outlook, including community or online college courses.
• It is critical to learn from those who are not just above you in title, but also have the characteristics that you identify with and want to build into your own professional persona.

IS THERE A SECRET TO GETTING A PROMOTION? WE interview professional Medical Management nurses (that is Case Management, Utilization Management, and Quality Management) on a daily basis and often candidates express interest in moving from staff-level positions to management opportunities. We recently published a paper entitled “The Road to Medical Management Leadership” that addresses the key components for getting promoted into leadership roles such as that of a Supervisor, Manager, or Director. In this document, we aim to shed some light and share our professional perspective as well as insight from leaders who have successfully transitioned into roles of increasing oversight, demand or responsibility.

As Medical Management recruitment consultants, we encounter accomplished leaders that are making a positive impact in Case Management, Utilization Management, or Quality Management departments throughout the country. Here, we aim to shed some light and share our professional perspective as well as insight from leaders who have successfully transitioned into roles of increasing oversight, demand or responsibility. So what did it take for these individuals to get from staff-level capacities to supervisory, management, and director-level leadership roles? Well, many professionals we’ve talked to have taken very different paths to get to the positions they are in now. However, there are common themes that consistently present themselves when working with professionals in leadership roles.

Medical Management Leadership Requires Longevity in Work History

First and foremost, strong candidates have long-term employment longevity with reputable organizations. In dealing with hiring managers at various provider and payer organizations, one element of consideration of a strong candidate is that they have great longevity in their recent employment experience. Even if you have not been totally happy in your position or positions, changing jobs frequently, regardless of the circumstances, never bodes well when searching for a leadership position. Additionally, many opportunities to rise through the ranks and gain a reputation as a reliable employee often lay the groundwork for future leadership options. Many leaders in Case Management, Utilization Management, and Quality Management have climbed into their roles simply from gaining tenure and outlasting those individuals that could not weather change or otherwise sought other opportunities.

We recently placed a nurse who had worked at United Healthcare for the past 5 years, working in a Utilization Management capacity doing Concurrent Review work. Our client immediately saw the value of her experience and longevity and psychologically must have thought, “This person could potentially be an asset for our organization for the next 5 years.” That is the powerful implication of strong work history with longevity at each position. That candidate is now a Manager of Utilization...
Management with our client.

That is not to say that if you have worked in a variety of contract roles for different managed care companies doing Case Management or Utilization or Quality/HEDIS, etc., then you won’t be a good fit for an organization or that it would prevent you from moving up throughout the ranks but you must be cautious about how you display that experience on a resume so as not to be perceived as a ‘job hopper.’ Often this variety of contract assignments was secured through a single staffing firm, so it presents better if your resume lists continually employment at that one staffing firm, with the individual contract assignments nested under that.

**Strong References Can Help Secure Your Next Medical Management Position**

Great candidates provide great references from managers to which they had directly reported. Lack of solid references when applying for leadership positions outside of your present employment can be a deal killer. More often than not, people that apply for positions without a solid list of four to five management level references leave a suspicious trail that good employers are hesitant to follow. After years in the recruiting business, we have found that some of the reasons candidates say they cannot provide references is generally telling of a not-so-spotless employment past. Providing solid references at the earliest stages of consideration demonstrates your ability to be proactive and that you have had a solid work past that allows others to brag about your value.

We recently had a Registered Nurse (RN) candidate under consideration for a Supervisor of Utilization Management position with a Managed Care Organization that specializes in Medicare & Medicaid contracts. She was one of several candidates that our client was considering through their interview process, but was the last candidate from our firm that was still being deliberated. Fortunately she was able to provide strong references from her prior employer, a very similar type of health plan. She did not simply offer a peer reference that worked with her in the Prior Authorizations department, but she also listed her Manager of Utilization Review, as well as the Director of Medical Management. In order to strengthen her candidacy, we chose to secure references from these leaders in advance of her being offered the position. Once we had the actual employment reviews from her references, we immediately shared those with our client. That tipped the scales in her favor, and put her ahead of other candidates. Prior to that, the hiring manager had only resume information and interview performances on which to base a decision; the past work performance of each candidate remained a mystery, until we provided those reference check results. She is still there today, and serves as living proof of the power of strong references.

**Medical Management Leadership Means Advanced Education & Certifications**

The best candidates have advanced education and certifications specific to their profession. Ten years’ ago, as we went through the recruitment cycle with medical management candidates, we found that many Managed Care Organizations and hospitals would substitute a certain amount of experience for education. That trend has spiked significantly since the downturn of the economy and advanced education, certifications and enhanced credentials have become a mainstay requirement. Completing a Bachelor’s Degree in Nursing or accomplishing an RN to MSN program shows employers that you’re invested in your career, willing to commit to a long term goal, and see it through to fruition. Similarly, completing an advanced certification related to your job function, such as becoming a Certified Professional in Healthcare Quality (CPHQ) or a Certified Managed Care Nurse (CMCN), demonstrates your commitment to your specialization.

“Schooling is very important. I went back to school after 35 years because degrees are more and more of a requirement, but more importantly, the content of the classes you take in obtaining that degree play into making you better at your job.” - Linda Novak, RN serves as Manager of Case Management for an Arizona health plan.

Going through the daily cycle of your responsibilities can be burdensome alone, but true leaders are always looking to heed Dr. Stephen R. Covey’s well-known advice to continually “sharpen the saw” and maintain the edge through continual education and professional certification. To broaden the opportunities of available leadership consideration, you must take the time to know your profession. Interacting with others in your field will help you stay aware of trends. For example, if you are a Nurse Case Manager, be active in your local chapter of the American Case Management Association (ACMA) or Case Management Society of America (CMSA). Learn about specialized certifications offered in your Association. Displaying that you earnestly strive to obtain and maintain professional certifications shows the employer you are progressive and would promote a culture of ‘doing’ not just
asking’. Employers trust their leadership to ‘doers’ and those that can set a good example for their team to follow.

For more information on educational programs and certifications specific to medical management, please visit our resource page at carenational.com/resources.

Medical Management Leaders are Tech-Savvy

Just as paper medical records are being replaced with electronic medical records, the advent of smart phones, tablet PCs, social media and other technological solutions have heightened the importance of technology skills in a candidate. The challenge is that many people still have not embraced the change into the information age. To make any sort of headway as a leader in medical management, you must become comfortable with the fact that your patients/members, supervisors, peers, and subordinates will in some fashion be connected to technology in their professional and personal lives. Although it’s not imperative to be a super user on Twitter and Facebook, there are many computer skills that should be embraced and developed. Being a basic (I know how to log on and can send an email) computer user really does not cut it anymore. Dedicated case managers, utilization review personnel, and quality improvement staff seek every opportunity to refine their use of programs such as Microsoft Word, Excel, PowerPoint, and Outlook, including community or online college courses. Understanding the latest Windows operating system as well as these commonly used programs is imperative to leading a group of medical management professionals expected to produce results with these programs.

The critical nature of this technological skill set is regularly emphasized by many of our health plan, hospital, and managed care clients. From staff to director and beyond, healthcare professionals in Case Management, Utilization Management, or Quality Management are relying on their technical talents more than ever. Depending on the specifics of the position, they will directly inquire if a candidate we have submitted to them truly possesses the computer skills to perform their duties effectively. Of course whenever possible, we work with our candidates to help them effectively emphasize on their resume any training or experience using specific computer or healthcare information technology (HIT) programs prior to submitting. Many organizations will have a prospective candidate complete a series of tests to evaluate their typing skills (words per minute or WPM), general computer program skills (Excel, Access, Word, etc.), and/or specific healthcare software (EPIC, CERNER, etc.). These tests are often one of the final stages of the consideration process, but they should not be taken lightly. At times this has been the deciding factor in selecting one candidate over another less-technologically adept nurse.

Even if you do not consider yourself to be very computer savvy, or even if you feel like every day is a zero-sum battle between you and your organization’s EMR, databases, or other programs, do not dismay. Establishing or developing basic, intermediate, or even advanced skills with standard computer programs does not have to be painful. While highly advanced user skills might require a college-style course, fundamental skills with common Microsoft Office programs, such as Outlook, Word, or Excel, can be attained or refreshed by utilizing a handful of online training websites, blogs, and videos; many are even free. Many times a candidate possesses the raw skills to use these tools on a daily basis, but is concerned on their ability to demonstrate that in a test environment. Often we are able to provide a few practice test resources so a nurse candidate can refresh themselves on their typing or computer skills. (These training and testing sites are available on the resources page). This only enhances their performance when it comes time to take the test with their potential next employer. We even assist a few of our clients with the administration of third party computer and typing tests, removing the burden from them. No matter the circumstances we partner with our candidates so they feel ready for every step of the consideration process, from resume, to interviews, to specialized testing.
Mentors are Guides on the Road to Medical Management Leadership

The best candidates, seeking to advance into leadership roles, find a mentor. The road to leadership in Medical Management was paved long before you desired this career path. Every leader today, whether the Director of Quality Improvement for an Acute Care Hospital or the Senior Director of Utilization Management for a Medicare Health Plan, has progressed through the necessary steps to obtain the positions of responsibility they hold now. These leaders, and we all know one or two, can be an excellent resource and a prime candidate as a mentor as you make your own way down your career path.

“Mentorship has been key to helping my confidence and is critical to progression in to a leadership role within case management. Without a mentor, you will be faced with things you have never been faced with before and not know what to do. One of the hardest things you will do as a Manager is to face change.”
- Richard La Sota, RN is a Case Management leader for a Phoenix healthcare provider.

It’s important to find mentors that have demonstrated leadership skills. You should spend time both on and off hours to learn from the people whose positions you would eventually want to be in. Find good mentors who you respect and who you see as successful at their job. - Linda Novak, RN serves as Manager of Case Management for a Phoenix area health insurance organization.

As pointed out by both La Sota and Novak, it is critical to learn from those who are not just above you in title, but also have the characteristics that you identify with and want to build into your own professional persona. Choose someone you respect and admire, don’t be afraid to ask questions, and put in the extra time to get exposure to your mentor. Leadership doesn’t come overnight. Be patient and be open to learning from somebody else’s experience.

The key is to latch on and soak in the vital information and advice you will get from the mentor. You may not always agree, or want to utilize the advice, but it will be a valuable part of your knowledge base and yet another tool in your tool box to ensure long-term career success!

Conclusion

Therefore, we advise nurses interested in leadership and development to take these five themes to heart. It’s never too late to establish a history of employment longevity, get great references from your managers, go back to school or to get certified, update your computer skills, or find a mentor to latch onto. Companies we work with on a daily basis are seeking highly motivated, talented and amenable candidates who are willing to go the extra mile to ensure their members/patients have the best medical care available. Recruiters, like us at CareNational, can present you with opportunities to take that next step, but it is up to you to ensure you have the right tools to move forward.

About the Authors

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CareNational Healthcare Services specializes in career consulting and recruitment within the Medical Management segment of healthcare, with focus in four primary areas: Case Management, Utilization Management, Quality Management, and Reimbursement Management.

CareNational is based in the Phoenix, Arizona area, but we operate from Coast to Coast, with openings from Boston, MA to Los Angeles, CA; Seattle, WA to Miami, FL. We work with organizations on both the payer and provider side, but always staying in the specialized niche of our four focus areas. Our clients include prestigious national Health Plans, emerging healthcare delivery models, and some of the oldest, most respected Hospitals in the country. We also work with specialized care providers, workers’ compensation companies, HMOs, Medical Groups, IPAs, and TPAs. Our candidates are primarily licensed clinical nurses, but they do range the whole depth and breadth of Health Care professionals working in our niche focus areas.

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A Prescription for the AGPCNPs

Adult-Gerontology Primary Care Nurse Practitioners (AGPCNPs) are in a unique position to shape the future of healthcare. The demand for AGPCNPs is as great as their impact.

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There are over 192,000 NPs practicing in the United States. The BLS expects 34% growth for the occupation during the 2012-22 decade.

There is a great need for nurse practitioners with an Adult-Gerontology specialty.

19% of NPs focus on adult care.

3% of NPs focus on gerontological care.

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Responsibilities of the Adult-Gerontology Primary Care Nurse Practitioner

As an Adult-Gerontology PCNP, you will fill a very important role in the healthcare system, by working autonomously and providing overall care for adult and aging patients.

Responsibilities of an Adult-Gerontology PCNP include:

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- Discuss pain management and care options
- Nurse practitioners are responsible for assessing the patient’s health status.
- They must prioritize the data to develop a plan for patient care.
- Order and evaluate screen tests to aid in preventative care.
- Adults between the ages of 18 and 64 see a medical provider an average of 4 times a year.
- Adult patients who report fair or poor health see a medical provider an average of 12 times a year.
- Nurse practitioners manage many aspects of a patient’s care, including the prescription of pharmacologic and non-pharmacologic treatments.
- Nurse practitioners educate patients on pain management so they will understand how to care for themselves at home.

The U.S. population age 65 or older is expected to double, reaching 72 million, over the next 25 years.
Ebola its Effects and Treatment on the African Diaspora
Angela Young RN, BSN and Jamesetta A. Halley-Boyce, RN, PhD, FACHE

Summary

Until 2014 there were no reported diagnosed cases of Ebola virus in the United States. However the effects of Ebola have been felt among the many American African communities. Ebola has been located in Nigeria, Liberia, Sierra Leone and Guinea, just to name a few. The Ebola virus disease, which is also known as Ebola hemorrhagic fever has been around for decades on the continent of Africa. This disease is still considered a rare disease which may be caused by one of five Ebola Virus groups. This disease process may form in humans as well as animals. The infection in humans is caused by one of four viruses. Ebola’s natural host has not been identified. It has been speculated that the Ebola virus is animal borne. It has been suggested that the Ebola virus can be spread from person to person through human contact. There is no credible Ebola virus vaccine available.

Key Points

- Ebola Virus Disease may be mistaken for conventional infectious diseases.
- Digestive indications usually occur approximately 5 days after symptoms.
- Ebola virus can invade the patient through mucous membranes, and disruptions in the skin.
- It is essential that individuals working in healthcare prevent direct contact with blood and body fluids, contaminated equipment, and soiled environmental surfaces.
- Travelers with possible exposure to Ebola virus may need public health monitoring and movement controls depending on the risk of exposure and clinical presentation.
- Primary care providers need to work with local or state health departments to prevent the spread of disease.

THE EBOLA VIRUS HAS CAUSED SURPRISING LEVELS of illness and death amongst individuals living in Guinea, Sierra Leone and Liberia over the last three years. There has been a reported 850 instances of Ebola virus in health care workers in West Africa. The first case of diagnosed Ebola virus in the United States was in September of 2014 in a Liberian man who expired after traveling here.

According to an article written by Frieden et. al 2014 in the New England Journal of Medicine, “no outbreak has been as large or persistent as the current epidemic, and none has spread beyond East and Central Africa”. In 2014 there was an epidemic of Ebola virus across the heavily populated areas of Lagos, Nigeria, this problem was of great concern to the United States due to frequent travel of Nigerians to America and other vulnerable countries.

Staten Island is home to the largest population of Liberian immigrants since the 1980’s. Many of these immigrants have lost family to the Ebola virus. There is fear that their neighbors will reject or avoid them. Many of the immigrants living in little Liberia fled the 14 year war in their homeland to find peace and acceptance here in America.

The Centers for Disease Control and Prevention (CDC) has initiated guidelines for detecting, separating, diagnosing and treating patients and others who may come into contact with the virus in their travels to minimize the risk of exposure to the Ebola virus.

Signs and symptoms

Signs and symptoms may appear anywhere from two to twenty one days after exposure to the Ebola virus. Symptoms are treated as they appear. Recovery is dependent on the patient’s immune response and supportive clinical care. Individuals who recover from this disease develop immunities to the disease for a period of ten years. The signs and symptoms are as follows: Fever, severe headache, muscle spasm, weakness, diarrhea, vomiting, abdominal pain, unexplained hemorrhage, and fatigue.

Transmission of disease

The natural reservoir of the Ebola virus has not been identified. However scientists suggest that the individual contracts the Ebola virus through contact with an animal, such as a fruit bat or monkey. Once infected, person to person transmission of the disease leads to large numbers of individuals being infected. Past outbreaks
of the Ebola virus have been attributed to “spillover events” where primates were affected and people touched or ate infected primates. Ebola can be spread through bodily fluids, and objects that have been contaminated with the virus. Ebola has been detected in a variety of body fluids including breast milk, saliva, semen, stool, sweat, tears and urine. Healthcare providers caring for Ebola patients, families and friends in close contact are at highest risk of contracting the virus. Ebola virus may be transmitted though contact with contaminated surfaces and objects. The CDC indicates that the virus on surfaces may remain infectious from hours to days. During outbreaks the disease can easily spread throughout the healthcare setting, if staff is not wearing appropriate personal protective equipment. Equipment for use needs to be dedicated to the patient only. Proper sterilization and disposal of equipment is very important.

Diagnosis

Early diagnosis of Ebola is problematic due to the generalized symptoms of fever, which is often seen in other infectious diseases such as typhoid fever and malaria. If the signs or symptoms of Ebola are noted in patients they should be separated from other patients and public health officials notified. Lab samples can be obtained to confirm the infection. The Ebola virus is only detected once fever symptoms develop which go hand in hand with the elevations in virus throughout the patients system. The Ebola may take up to three days after the beginning of symptoms for the virus to be detected.

Treatment

There is no FDA approved vaccine or medication for the Ebola Disease. Symptoms are treated as they appear. The following interventions have been suggested by the Centers for Disease Control as significantly improving the chance for survival:

- Providing intravenous fluids and balancing electrolytes
- Maintaining oxygen status and blood pressure
- Treating other infections if they occur
- Experimental vaccines and treatments for Ebola are under development, but they have not yet been fully tested for safety or effectiveness
- Recovery from Ebola depends on good supportive care and the patient’s immune system

There is increasing evidence identified through the collective experience and numerous Ebola virus outbreaks since 1976 that suggests Ebola can be considered a zoonotic disease that has appeared and increased as human contact with wild animals has increased. In addition ecological, epidemiologic and clinical disease surveillance will remain important throughout Ebola pervasive nations. The importance of investigating possible
The economic impact of Ebola on the United States

The Ebola outbreak of 2014 was predicted as causing greater than a million and a half cases. This motivated the US government to actions that would control or eradicate the spread of the virus at its origin and the military response was increased to support the civilians in West Africa. There were also actions in place to isolate the Ebola virus now and at any other time in the future on US soil. The US committed $2 billion to fight Ebola in West Africa. There was also an additional $3.4 billion dollars contributed by donors, one hundred and thirty epidemiologists and other healthcare workers. As of July 2015, the US government had committed an additional $266 million to support the continued recovery efforts in West Africa. According to the WHO, approximately 200 to 250 health workers are needed to adequately care for each 80 cases of Ebola.9

According to a statement by Alphonso Lenhardt, acting administrator, “the American people have demonstrated resolute commitment to tackle the scourge of Ebola.” The ripple effect of the Ebola virus has threatened the education of youth and caused a decline in trade efforts with the closing of borders to the countries affected by the virus. The Ebola virus has stretched the limits of institutions and the basic organizational framework. The goal is to have “zero cases” here and abroad. The United States has continued to commit to assisting the affected West African countries. Present cases of Ebola in West African countries are down to 20 cases instead of the 100 cases one year ago.7 Any case is unacceptable, however, time has shown that a unified effort can contain the spread of the disease and reduce transmission of that disease.

Although we have stated what is believed to be the economic impact of Ebola, in reality no one has fully calculated the cost to the health care system as it relates to training, testing, treatment, waste disposal and particularly all of the hospital beds that have been left vacant in those designated ISOLATION Areas. Sorkin writes, “Perversely enough, many of the health care costs could conceivably help that industry in the short term because additional money is being spent.”10

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References

Why Hospitals and Payers are Recommending Home Care upon Discharge Instead of SNF or Traditional Home Health Services  
— Alternative Payment Model Hospital Incentives Aligning with Patient Choice —  

Dr. Josh Luke, Ph.D., FACHE and Susan Condie, Ph.D.(c), MSN, RN, CNS, PHN, ACNS-BC, CNE, NE-BC

Summary
Seniors and other hospital patients in the United States have traditionally had the option of being discharged to a skilled nursing facility (convalescent home) for post-acute services, or home with nursing and therapy services provided in the home setting. Traditionally, these home-based services have been referred to as “home health.” As more Americans retire, home health services are readily accessible and expanding. This growth put tremendous stress on the Medicare fund which pays for senior care services. However, “Home Care,” which traditionally has been viewed as non-medical home based services, has also become a booming industry for the cost-conscious in recent years as more Americans reach retirement age. With the passing of the Affordable Care Act in 2010, providers and payers now find themselves responsible for post-acute care and continuous patient health, so cost-efficient solutions for post-acute care are thriving. For the first time in history, American hospitals and insurers are recognizing Home Care as an effective model that achieves the Triple Aim of Health Care reform.

Home Care, which is no longer completely non-medical services, has proven to be an integral part of the care continuum for seniors in recent years and a viable solution for keeping patients well, while still honoring their desire to age and heal at home. This paper analyzes the benefits and risks of home care and provides a clear understanding as to why American hospitals are avoiding SNFs and skipping home health, opting instead to refer patients directly to home care as the preferred discharge solution in a value-based model.

Key Points

- 90 percent of seniors prefer to age and heal at home as opposed to in a healthcare facility.
- Patients in an acute hospital have the right to be discharged to the least restrictive environment when the care team determines that community placement is appropriate and the patient does not oppose the transfer.
- Hospital discharge planners assume the patient (and family) do not have the financial means to pay for home care, or simply opt not to pay as traditional home health is a covered Medicare benefit. Financially vetting each patient and family upon discharge can be a time-consuming process and may delay discharge. Thus, as a result of these two factors, patients are rarely informed that home care is an option upon discharge from the hospital.
- Ultimately, the patient’s specific needs may be less expensive and acute than a $200-$800-per-day SNF stay, or a $3,600 home health episode. As a result, hospital discharge planners and payers are moving quickly to consider home-based care with non-medical home health a first-option before considering a SNF stay or home health order.
While the triple aim of (PPACA) is improved care, patient satisfaction and lower delivery costs, recent recommendations from the Centers for Medicare and Medicaid Services (CMS) also emphasize the importance of involving patients in decisions related to their care. The patient’s perception of his or her health care delivery correlates with outcomes and, ultimately, satisfaction.  

In October 2015, CMS reinforced its desire for patient preferences in the hospital discharge process in a press release, with Acting Administrator Andy Slavitt framing it as a “simple but key change that will make it easier for people to take charge of their own healthcare. If this policy is adopted, individuals will be asked what is most important to them as they choose the next step in care — whether it’s a nursing home or home care.”

The final part of that quote, “whether it’s a nursing home or home care,” will drive hospitals to send fewer patients to skilled nursing facilities (SNFs) and home health in 2016 and beyond. Put simply, when given a choice, patients will opt not to go to a SNF unless it is viewed as a last resort.

As further evidence of the Federal Government’s drive to reduce inpatient post-acute care utilization, the Affordable Care Act mandated the creation of the Community Living Assistance Services and Supports Act (CLASS), a national long-term care insurance program with a daily financial benefit that covers up to (the industry standard) three hours of home based care per day per enrollee.

**Fee For Service Drove Inefficient Hospital Discharge Habits & Excessive Spending**

Case managers and discharge planners have historically been charged with developing a comprehensive discharge plan for each patient in an acute hospital. However, time constraints and information-overload facing doctors, nurses and discharge planners led to discharge plans that were brief, free of detail and often non-existent beyond an order for “discharge to SNF.”

Hospital discharge planners, some of the most overworked professionals in all of the healthcare industry, are asked to manage the constant flow of multiple patients a day. Coupled with a new case load that completely turns over every four to five days, hospitals pressured case managers in the 1990s and 2000s to facilitate each patient’s timely discharge to keep hospital costs low. The requirement to arrange discharge accommodations for acute patients led to less time and less reserved resiliency to adequately document the patient’s needs in discharge plans and summaries.

These added pressures led discharge planners to the path of least resistance to discharge patients in a timely manner. In short, for patients with a Medicare benefit, a SNF or home health agency (in the event the patient refused a SNF) became the quickest and easiest way to get the patient out the door and open up the hospital bed. Additionally, doctors were hesitant to avoid skilled nursing and home health services even when a patient refused due to concerns the patient would experience an adverse outcome or decline in health after discharge.

During this ever-eroding discharge process during the fee for service era, hospitals lost the notion that patients would prefer not to be admitted to a SNF. Essentially, patient preference in level of care was not proven to be a factor, but simply a means of allowing the patient or family member to choose their preferred SNF, and not whether they truly needed SNF-level care unavailable in a home setting.

Subsequently, SNF and home health volumes increased dramatically. Patient involvement and preference to avoid skilled nursing was no longer a factor in the conversation.

**US Supreme Court Rules Patients Should be Discharged Directly Home**

For years, the Federal Government has had legal muscle to encourage doctors and hospitals to send patients home and avoid the SNF, but has had little success doing so. However, the reimbursement model for physicians and providers in the fee-for-service era was prohibitive and inconsistent with that objective. The landmark United States Supreme Court ruling in 1999, Tommy Olmstead v. Lois Curtis essentially ruled that patients in an acute hospital have the right to be discharged to the least restrictive environment when the care team determines that community placement is appropriate and the patient does not oppose the transfer.

Furthermore, the ruling also means that institutionalization of patients who may be placed in less restrictive environments often constitutes discrimination based on disability. Thus, operationally, both physicians and hospital case managers must first rule out the least restrictive environment as a safe discharge before considering institutionalizing a patient for post-acute services.

**The Care Plan Act: Episode-Based Care Gives Way to the Permanent Caregiver**

One of the benefits of home care as an alternative to traditional home health services is that the caregiver becomes the long-term caregiver, and not a short-term episode-based care taker as is the case in SNFs, home health and other levels of post-acute care. CMS clearly stated their preference to reduce the number of the episodes of care and the volume of caregivers that come along with the episode. This leads to enhanced continuity, efficiency and improved outcomes. While SNF length of stay varies, it is often 20 days or less, and home health is normally a 2-3 month episode. Neither range allows for a long-term caregiver who assumes responsibility and knowledge of the patient’s needs as is the case in home care or assisted living.

“The proposed rule emphasizes the importance of the patient’s goals and preferences during the discharge planning process. These improvements should better prepare patients and their caregivers to be active partners for their anticipated health and community support needs...This rule puts the patient and their caregivers at the center of care delivery,” said CMS Deputy Administrator and Chief Medical Officer Patrick Conway, M.D., MSc. “This leads to better care, smarter spending and healthier people.”

**Incentives for Hospitals and Payers to Consider a Home-First Discharge Option**

**Hospital Incentives to Utilize Home Care as an Alternative to SNF or Home Health**

- Increased revenue as demonstrated through improved Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores
- Reduced Merit Systems Protection Board (MSPB) financial penalty exposure
Home care is often a higher level of care than traditional home care is an option upon discharge from the hospital. As a result of these two factors, patients are rarely informed that they have the financial means to pay for home care, or simply opt not to pay as traditional home health is a covered Medicare benefit. Hospital discharge planners assume the patient (and family) do not have the financial means to pay for home care, or simply opt not to pay as traditional home health is a covered Medicare benefit. Further, when a patient declines skilled nursing upon hospital discharge is more likely a result of an episode-based reimbursement model for providers and doctors than a clinically justified necessity. Further, when a patient declines skilled nursing care, the default option has been traditional home health services. Again, this is a short-sighted approach as home health services are often capped and limited to benefit allowances regardless of whether a patient needs additional care or therapy. Home care, for the most part, has not been offered as an option for patients being discharged from the hospital. There are two main reasons why hospitals rarely offer home care upon discharge. First, hospital discharge planners assume the patient (and family) do not have the financial means to pay for home care, or simply opt not to pay as traditional home health is a covered Medicare benefit. Second, financially vetting each patient and family upon discharge can be a time-consuming process and may delay discharge. Thus, as a result of these two factors, patients are rarely informed that home care is an option upon discharge from the hospital.

Home Care is Often a Higher Level of Care than Traditional Home Health

Home Care services provide daily living assistance to patients with physical, cognitive, or chronic health conditions. This workforce includes personal care attendants and other essential care providers who serve non-medical functions. Non-medical workers contribute eight to ten hours of paid services to older patients and to individuals with disabilities. There is growing evidence that these workers can improve patient experience and outcomes.

As mentioned earlier, traditional home health services are often capped and limited to what the benefit allows – even if a patient is in need of additional care or therapy. With CMS approving reimbursement for home visits, chronic care management and transitional care management, home care providers who partner with physician house call groups can offer a higher level of care and less spending than home health, as a physician or nurse practitioner visit is not a covered home health benefit and therefore not offered as part of the home health episode. Thus, home care often includes a physician, physician assistant or nurse practitioner visiting the patient in the home, whereas traditional home health are conducted with a nurse primarily.

The Argument for Cost Savings for Payers and Conveners

Payer Incentives to Utilize Home Care as an Alternative to SNF or Home Health

- Improved patient satisfaction
- Extended home based services times
- Diverse patient-specific needs not limited by home health benefit
- Risk pool saving

Although organizations traditionally viewed home care as non-medical care and therefore a non-covered benefit, many nationwide have started bucking this trend by employing non-medical home care services as a covered benefit that comes with a much lower cost than traditional home health services. For example, “the average non-medical worker is paid an hourly salary that is approximately 70 percent and 90 percent less than the salary of a nurse or physician, respectively.”

Conclusion

Alternative payment models have driven payers and providers to consider non-traditional methods of caring for patients to improve outcomes and control costs. While traditionally non-medical services were not covered benefits (assisted living was viewed as “rent,” and non-medical home care was viewed as “babysitting” by many), insurers and conveners find utilizing these non-traditional levels of care can ensure patient satisfaction and lead to significant cost savings. Assisted living placement often causes delays in discharge. However, home care referral and same-day start of care is often the best approach from a quality and financial standpoint as the patient’s desire to return to home is honored.

With the increasing number of alternative payment models and penalty programs being introduced, hospitals, doctors and payers are focusing on how the patient can receive the best care at home. When done correctly, patients can avoid admission to a hospital. However, preventing unnecessary readmissions is just one of many incentives to encourage more affordable and efficient home based care practices.
SNF as well as Medicare- or Insurer-based home health services which are often limited and capped at specific amounts. Each of these entities is adopting a “home-first” mentality and approach. The Improving Medicare Post-Acute Care Transformation Act (IMPACT) requires greater patient involvement in discharge planning, which will lead to more specific discharge plans with the primary goal of allowing a patient to age, recover, and heal in a home-based setting.

Ultimately, the patient’s specific needs may be less expensive and acute than a $200-$800-per-day SNF stay, or a $3,600 home health episode. As a result, hospital discharge planners and payers are moving quickly to consider home-based care with non-medical home health a first-option before considering a SNF stay or home health order.

Hospitals and payers should not only revise discharge protocols to consider a home-based discharge first — those who are doing so are experiencing enhanced patient engagement and improved patient satisfaction scores. Home care and a “home-first” mentality upon discharge not only reduce the risk of infection that comes along with a SNF stay, but improve patient satisfaction, reduce spending for care, minimize exposure to readmission penalties and over-utilization of Medicare funds, and enhance an organization’s ability to maximize risk pool residuals in alternative payment models. Hospitals that do not adopt a home-first mentality will incur significant losses in alternative payment models and will continue to feel the financial sting of allowing physicians motivated by fee-for-service to regularly dictate inappropriate post-acute plans without offering the patient the option of going home.

For insurers, medical groups and other payers, spending a dime to save a dollar often comes with great risk. Home care, however, is not a new service and has been proven to enhance the care continuum for years. Thus, payers are increasingly more willing to suggest discharge home with home care as an option before considering skilled nursing or traditional home health services.

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Care management falls under various titles and roles, whether it is nurse case manager, social work case manager, utilization nurse manager, and so on. Regardless of the wording of the position and the area of focus on the patient’s care, we need to remember that patient advocacy and improving the quality of care is the end goal and that innovative processes in care management services are more critical than ever.

**Key Points**

- Care management positions and responsibilities vary depending on the organization and its structure.
- The importance of care management is continually evolving with new legislation and best-practices.

It is almost impossible to open up an email, a journal (paper or electronic), or even webcast and conference brochures without reading something related to care management practices under the ACA. The health services literature is saturated with what I term, “best practices’ roammers” that are either looking for best-practices or those that are trying to clinch credit for best care coordination services and best outcomes. Many are confused about who to lure to their conferences, who to add to their practices that can really make a difference, or which consultant to bring on board to give them an edge ahead of the pack.

Acronyms concerning current care and best practices can be overwhelming even to health care workers, yet none of us slows down for contextual value to the consumers of health services. In this article, I’ll focus on ambulatory care and patient-centered medical home care (PCMH) and the expertise of care management services that are truly the nexus for patients’ health and well-being, while I’ll also address a pressing concern among cadets of nurses that elected the utilization review career path for many years and wonder about their career choice asking, “Will utilization review become extinct?”

In a recent white paper, focusing on the changing landscape of health care by Wellframe, a similar question was raised: “Who is responsible for care management?” While the focus of Wellframe involved the use of mobile-apps to “empower care managers to operate closer to the top of their license” and amplify care management efforts in a consistent and sustained communication yielding value-based interactions with patients, it was evident that many models of care have not yet started the path to true integration of care or payer-provider alignment regardless of their surface collaborative efforts.

The reality of current health care coverage and delivery is continued fragmentation, challenges with scalability of the myriad models of care, and reaching the masses of vulnerable and underserved populations that would benefit the most from care management services done right. The challenge remains identifying how that can be accomplished in the 21st century under the tsunami of technology.

Similarly Budryck (2015), highlighted the different models and misalignments as the forces impacting effective and value-based population health. Budryck also alluded to the “evolving and uncertain terrain” of health care as key reasons for that misalignment. However, from an experience-based perspective I see the focus on physicians’ delivery of care vs. other practitioners that are truly “boots on the ground” providing more interactions with patients, their care-givers, and the community-based providers they interface with. This is where additional blurry lines should be clearly marked when referencing care management or care coordination.

Many wonder about the differences between social worker case managers vs. nurse case managers. This differentiation is what I term “surface oil” as it constantly surfaces in every contract I have or had regardless of the setting. Typically, I use a tool that is grounded in the Standards of Practice for each role as identified by their respective societies, licensure and credentialing boards.
To give credence to this tool, it is important to consider the Institute of Medicine (IOM) briefing in February 2016 where multiple presentations and findings by thought leaders addressing the aging population and the importance of nutrition were accumulated in an effort to highlight the need for new models of care. Donnon (cited in IOM, 2016, p.2) stated that as the U.S. and the world is dealing with an “Age Quake”. It is important to facilitate successful aging through management of defined resources and identification of risk factors and determinants of health. Such concerns are typically addressed by mid-level clinicians like care managers who typically take the time to work with the elderly and vulnerable population and make time to explain things for them and their care givers as well as connect them to available community-based resources such as in-home supportive services or meals on wheels and the like.

Care Managers, social work or nursing, facilitate the care coordination of services and engage in continual re-evaluation and updates of the care plan. Through continued engagement with key providers particularly primary care providers, care managers work within the patient’s and/or care-giver’s perception of care needs, not to mention taking care to the setting where patients and their care-givers consider, for optimal health and wellbeing. So, while the current emphasis is on population health and integrated care, it is important for the industry to recognize the pioneers of care management and care coordination. These are the care managers that have been doing this for over two decades, delivering value to care despite a fractured system and adding more meaningful quality care outside the current defined peripheries of coding for reimbursement.

In a recent white paper explaining the “evolving landscape” of health care through the path toward proactive care of chronic disease and a focus on health wellness, one of the key strategies was the design of advanced clinical management and care models. The author(s) highlighted elements necessary for care models’ design that are necessary to meet the diverse needs of patient populations such as accountability for clinical outcomes, managing clinical variation in health status, and care transitions’ management. At the crux of clinical management are these care transitions that care managers became experts at over years of practice and adjustments as practices and regulatory standards evolved through the years. While thought thinkers can come up with what they think would work best and technological advances in terms of electronic medical records and predictive analytics defining efficiencies and effectiveness, it is the care managers who perfected the art
of managing and coordinating care over the years that can really make all these initiatives a reality for patients, providers, caregivers, and communities.

While turf battles concerning the ideal specialty to manage and coordinate care continue, the utilization review (UR) role is becoming an enigma in terms of its continued value to the evolving health care landscape. Many UR nurses are concerned about the viability of being locked-into such roles and often question if they need to find another venue to make a living.

I believe the health care turf is big enough for different specialties to work in harmony however, the role of UR is morphing from criteria-based reviews to coding, documentation, and inter-disciplinary care team’s work that would address quality of care and the patient’s or member’s experience thus, impacting reimbursement under a different version of their work. Using hospital work as an example, Cross stated that a historical focus on utilization management and treatment or processes occurring within the hospital walls must embrace change and focus on what occurs outside the hospital walls as well as contributing to readmissions and consequent “failed care” during hospital stay. The author called using programs like PACT which addresses hospital admissions as problems that must be traced to root causes, or T3 model (tria, transport, and treatment) to facilitate services that stabilize and support ongoing patient needs. Similarly, past Case Management Society of America (CMSA) President Skinner stated in her President’s letter to membership that case managers “planted many seeds and watched them grow. The seeds of advocacy and coordination of care through each transition…” and in their “happy dance” efforts to make sure patients get needed services and achieve desired outcomes for their care, case managers executed successes in patient-centered care under the current measures of safe, timely, efficient, and effective care.

In summary, innovative processes in care management services are more critical than ever. In a fast-paced industry managing a historic pandemic of legislative updates and changing reimbursements, care management cannot be content in occupying the caboose of the health care train. Whether the approach to care delivery is patient-centered medical home, telehealth, collaborative care or traditional fee for service, care managers are at the heart of it all if any desired outcomes are to be reached. We were always the trusted pioneers of care coordination and care transitions’ navigators for patients or utilizers of health services, and we must continue to be at the forefront advocating and facilitating care. Care Managers must stand firm against the tsunami of health care change through a big picture focus and they must stand solid in the front cart keeping this train on track. The “all aboard” call has always been resonating with care managers who tied the loose ends and connected the providers of care throughout the fragmentation of the health system pushing for safer care transitions and quality care for their patients. Let’s drop the titles or role-categories whether UR nurse, social work case manager or nurse case manager…etc., and let’s serve our patients and communities with the best care and health services they deserve regardless of the place of care.

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KEYNOTE SPEAKER
Jean D. Moody Williams, RN, MPP
Deputy Director
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Prescription, OTC and Complementary Medicine Use among Hmong Adults in Central California

Felicia Hodge, Suzanne Kotkin-Jaszi, Mohammad Rahman and Fernando Martinez

Summary
This study focuses on the use of prescription, OTC, and complementary medicine use among a community of Hmong in Central California. The study showed that while seeking assistance from health care providers is the preferred choice of many Hmong residents in Central California, a significant number continued to use complementary medicine (from a shaman) to treat illness. Culturally appropriate education should be employed to improve and maintain communication and healthcare interactions.

Key Points
- The Hmong are an indigenous group originating from Northern Laos. Groups of Hmong families fled their homes or faced persecution or death from the communist Pathet Lao. The Central Valley was a popular choice for relocation due to available farm land.
- The Hmong of the Laos Highlands traditionally use herbs and spirituality to heal.
- 51.4% of the study participants reported that they turn to complementary medicine if they cannot pay for healthcare from western providers, and 41.1% used a shaman within the past year.
- It is important to recognize that as long as the herbal medications and shamanic practices are not harmful, they are not competing with western medicine but supporting the patient in a time that most patients can find stressful.

INTRODUCTION
Prescription medication and non-prescription medication (otherwise known as over-the-counter, or OTC medication) are common and readily available to treat illness. Many individuals, however, choose the use of complementary medicine instead of or in conjunction with prescription or OTC medication. The reasons for using complementary medicines and its perceived effectiveness may vary among age, gender, or racial/ethnic groups. Better understanding of health-seeking behaviors, particularly in regards to medication use, can aid healthcare providers in counselling and treating indigenous populations such as the Hmong.

Studies document that the Hmong continue to prefer their own ancient medical traditions even after they have immigrated to the United States. The use of shamanistic ceremonies in combination with Western biomedical medicine is preferred by elder Hmong Americans and their family caregivers. Little is understood concerning the use of complementary and alternative medicine (CAM) but recent meta-analysis of studies of the Hmong found that CAM may not be an alternative practice, but rather the dominant form in their home countries. The combined use of Western medicines and complementary Hmong medicines, and the identity of the condition that each is used for is of interest to researchers and providers alike as mixed medication may be harmful and providers require full disclosure of medication for appropriate medication counselling.

The Hmong are an indigenous group originating in the mountains and hills in Northern Laos. Since the end of the Vietnam War in the 1970s, groups of Hmong families fled their traditional homes in the mountains of North-eastern Laos or face persecution or death from the communist Pathet Lao. The Central Valley was a popular choice for those who came to California, because of the availability of agricultural land that allowed these refugees to continue their farming tradition. Because the Hmong has been exposed to Western medicine since the mid 1900s, the use of dual medication use is becoming more frequent. Complementary herbal medicine, however, continues to be used to treat various illness and physical symptoms.

Complementary medicine is comprised of herbal remedies, meditation, visualization, message and chiropractic care, spiritual practices and prayer, acupuncture and vitamins. The Hmong of
the Laos Highlands traditionally use herbs and spirituality to heal. Depending upon the group, categories of complementary medicine use may be used exclusively, in combination, or in prescribed stages. Also, the use of complementary medicine can be exclusive or in conjunction with prescribed or OTC medication.

The use of prescription, OTC, and complementary medicine use among a community of Hmong in Central California is the focus of this paper. We identify the condition(s), related communications, and the perceived benefits of various medications. Recommendations for treatment and counselling indigenous groups are provided.

Methods

Sample

One hundred and seven adult Hmong participated in the study; 58 (54%) males and 49 (46%) females. Inclusion criteria included: (1) age 18 years and older, (2) self-identified Hmong, (3) resident of the city of Fresno, California, and (4) member of the selected household.

Design

A cross-sectional household study was implemented among the Hmong residents of Fresno, CA. To obtain the recruitment frame of Hmong households, the Fresno-Clovis, California telephone book was used to identify Hmong surnames. Undergraduate students, under the supervision of a faculty member, called the 17 telephone numbers associated with Hmong surnames and asked if they would be willing to participate in a 15-30 minute survey. All participated and the total number of adults recruited from the 17 households was 107, or approximately 6-7 adults per household. Arrangements were made to administer the survey in person to all adult Hmong members of the selected household. Interpreters were provided for those who could not speak English or who requested an interpreter.

Data collection method

A questionnaire on health practices and use of prescription drugs and complementary medicines was administered in a structured approach. Trained undergraduate students from the Fresno State University Department of Public Health contacted each identified household by telephone, US mail and by personal contact to recruit respondents and to coordinate the student-administered survey with each adult resident of the household. Respondents were provided verbal and written information on the study and consenting took place in their households or in the clinic/community meeting room. The voluntary nature of the study was explained, carefully noting that services at health care clinics or community centers were not contingent upon their participation in the study. Institutional Review Board (IRB) approval was obtained from Fresno State University, Department of Public Health, and Committee for the Protection of Human Subjects. Surveys were collected and hand-carried to the project leader, who then coded each complete survey to protect confidentiality as individual identifies such as names, addresses were not recorded.

The following items were measured in the survey:

Socio-demographics: Questions were asked regarding participant’s age, gender, marital status, education, and employment status. In addition, questions were asked if they needed an interpreter to assist them in their conversation with providers and their ability to read instruction labels.

Health-seeking behaviors: Participants were asked if they seek the help of healthcare providers or shamans for their illness. They were also asked when, why and how participants sought out health care.

Use of prescription, OTC, and complementary medicine: Reasons for use, importance of use, treatment effectiveness, and the last time used of the following: prescriptions ordered by physicians, over-the-counter medication, and complementary medicines. Each measure was dichotomized into two categories for the chi-square test.

Communication with provider: Participants were asked if they informed their provider about their use of prescription, OTC, and complementary medicines. They were also asked if their provider spent enough time with them, discussed medication side effects, if they asked the provider questions, and if they understood the medication instructions.

Data analysis

The completed surveys were cleaned and coded. The results were entered into an Excel computer program and analyzed using the SAS Statistical Analysis Program (SAS Institute, 2011). Chi-square tests of association were used to assess if there was a relationship, or statistical difference in the measures. The study’s outcome variable of interest, use of medication, was examined among the categories of prescription, OTC, and traditional medicine. Differences were further examined by importance of medicine/drug use, and the last time used. Health beliefs (usefulness and purpose of medication use by prescription, OTC and complementary medicine) were examined and health-seeking behaviors (communication with physician and outreach) was reported. All statistical analyses were performed with a Statistical Analysis Program (SAS/STAT) (Cary, NC, 2011). Statistical significance was set at \( p < 0.05 \).

Findings

Table 1 reports on the socio-demographic characteristics of the study participants. A little over one-half (54%) of the 107 Hmong who participated in the study were male, 54% were married, 49% unemployed, and 26% had no formal education. Participant age ranged from 18-70 years. Forty-nine percent reported they used an interpreter because of language barriers, nevertheless, 77% reported that they were able to read the instructions on medication labels (Table 1).

The health beliefs of respondents were measured by individual’s perceived usefulness and purpose of medication/drug use. More respondents reported that prescription medications were more helpful (77.6%) than OTC (67.3%) or complementary medication (43.0%). In addition, 61% of the sample reported that prescription drugs treated most of their symptoms, as compared to 56% for OTC and 47% complementary medicine. Females were significantly more likely to report that they used complementary medicines within the past year (39.5%, \( p = 0.025 \)). This finding was
significantly higher than the small percentage reported by males (14%). When asked “How important is it for you to use” these drugs respondents were more favorable in their responses as 72% felt that complementary medicine was somewhat, important, or very important and 85% of prescription and OTC drug use was reported in these categories. Prescription and OTC drugs were used largely for pain (66.7% and 72.9% respectively), whereas only 8.4% use complementary medicine for pain. Sixty-seven percent reported complementary medicine/drugs were used for such ailments as hypertension, stomach and intestinal problems, and other illnesses.

Health-seeking behaviors were observed in participant’s choice of healthcare provider (61.7%) over OTC drugs or shamans/herbal medicines (21.4%) for illness or injury. However, 51.4% reported that they turn to complementary medicine if they cannot pay for healthcare from western providers. Seventy-five percent felt that the shaman was helpful, 83% felt that it is important for them to ask a shaman to treat their illness, and 41.1% used a shaman within the past year.

Use of Prescription Medication

Sixty-two percent of the participants reported that they seek the help of healthcare providers for various illnesses, and that these encounters result in the use of prescription medication. Fifty-five percent used prescription medications during the past year for several physical complaints, largely for pain in the chest, neck, or back (66.6%) or for intestinal illness such as diarrhea, hypertension (high blood pressure), and other illness (33.3%). Because of language barriers (the majority of participants either did not speak English or identified English as a second language) 48.6% needed an interpreter to assist them in their conversation with providers. A major barrier to obtaining prescription medication was financial; 51.4% reported they had problems paying for their prescription medication.

When we examined medication use by gender, differences were observed between those who reported prescription drug use, over-the-counter use, and complementary medicine (Table 2). Fifty percent of Hmong males reported using prescription drugs over their lifetime, a little more than females (51.8% males v. 48.2% females). Males consistently reported higher prescription use for pain symptoms (23.9% v. 18.2%), and males and females equally felt it was more important (42.9% v. 42.9%). Both males and females reported that prescription drugs were very helpful/a lot helpful (46.2% v. 45.2%) to them. Table 3 reports on the use of prescription, OTC, and complimentary medication use among the participants. A chi-square analysis shows statistical significance between all three categories for each of the questions. This table shows that although participants used prescription drugs, they continued to use it in conjunction with OTC and CAM. Also, use of prescription medication was used by 55% within the past year, and it was used for chest, back, and neck pain (67%), and it was deemed as very helpful (85%). A majority of participants reported that the prescription drugs were positive and helpful (88%) and very few (13%) thought it was negative, dangerous, or evil.

Use of OTC Medication

Study participants indicated that over-the-counter (OTC) medications were used frequently and often in conjunction with prescription medication. Sixty-one percent of participants reported that they used OTC medication within the past year. There was little or no difference in the OTC use patterns between male and female participants. Eighty-two percent of participants (46.7% male and 35.6% female) used OTC medications for bodily complaints such as stomach and intestinal complaints, hypertension, asthma and other illness symptoms. Few used OTC for head and body pain (7.5% male, 11.2% female). Ninety-three percent felt that OTC drugs were very helpful to treat their physical complaints, and 74% felt it as positive (Table 3), 25% felt the use of OTC medication it was “necessary but evil.”
Use of Traditional Medication

As reported above, significantly more females than males reported using complementary medicines during the past year (39.5% female vs. 14% male, p=0.025). Bodily symptoms, such as stomach and intestinal problems, asthma, and other symptoms were reasons for the use of herbs and other traditional medicines. Both males and females (34.3%, 35.2% respectively) thought that herbal medicines treated most of their symptoms and that it was very important medicine (50% male vs. 43.3% female).

Seeking the services of a shaman for physical complaints was reported by a large percentage of participants (75.7%). Participants explained that they felt going to a shaman or a spiritual healer was a positive event (65%), and that the treatments were helpful (20.6%), very helpful (34.6%), or helps a lot (38.3%). Only 10.3% felt going to a shaman was a “necessary but evil” event.

Communication

Although 49% of Hmong reported that they needed an interpreter to assist in conversation with their doctor (as 71% of the clinics they visited had an interpreter available to them), a large percent (82.2%) of the respondents reported that they felt their health care provider spent enough time explaining the usage of their prescribed medication. Eighty-four percent reported that the provider talked about the usage of the prescription, possible interaction of using multiple medications at once (70.1%), and medication side effects (71.9%).

Discussion

This study showed that while seeking assistance from health care providers is the preferred choice of many Hmong residents in Central California (62%), a significant number (75.7%) continued to use complementary medicine (from a shaman) to treat illness. These study results find a high percentage of Hmong residents in the Central Valley utilizing complementary medicine were also reported in a study by Helsel et al. in 2004 in Merced, California, a community in the Central Valley with a population of over 7,000 Hmong Americans. Similarly, an earlier study in the Central Valley conducted by Nutall and Flores in 1997 found that the Hmong are more likely to use shamanistic practices, herbal remedies, or talismans rather than western biomedical practices. This is especially true for problems related to soul loss and loss of life visa. Over-the-counter medications were used primarily for bodily symptoms and prescription medication was sought out for pain primarily of the chest, neck and head.

Programs targeting Hmong patients should be aware of the high usage of complementary medicine, indeed the possible co-mingling of prescription, OTC and herbal medicines for bodily symptoms. Culturally appropriate education should be employed to improve and maintain communication and healthcare interactions. It is also important to recognize that it has been almost thirty years since the first Hmong immigrants began to arrive in the US. For younger Hmong who were born in the US, there are many different health care options available from traditional Hmong shamanic and herbal practices to any number of complementary medical practices or to seeing specialized health care clinics with Hmong American physicians and nurse practitioners. Hmong Americans come from a culture that focuses on the group and family rather than the individual. By seeking out a shaman and utilizing traditional herbal medicines in combination with western biomedical practices, it may help to restore a sense of cultural connection to their group, their homeland, and those who were left behind because they had passed away or were too elderly to immigrate to the United States. Health care workers including nurses, public health educators and administrators need to be culturally sensitive to these traditional practices and recognize they may provide a deep sense of comfort and solace during an episode of illness. Suffering an illness while seeking care in a complex health care system, the Hmong are also often burdened by the cost of care as almost half of the respondents reported being unemployed. This stressful interaction with the western health care system is also exacerbated by the language barrier. It is important to recognize that as long as the herbal medications and shamanic practices are not harmful, they are not competing with western medicine but supporting the patient in a time that most patients can find stressful.

Conclusion

For nurses and public health workers who practice in areas with significant populations of Hmong Americans including California’s Central Valley, Minnesota, Wisconsin, North Carolina and other areas of refugee resettlement, it is of importance to understand the Hmong culture and historical experience. It is recommended that targeted healthcare practices that are culturally tailored to include both western biomedical and traditional herbal Hmong healing practices to show the greatest promise for providing

Table 2: Communications between Hmong patients and providers (N=107).
Hmong Americans with high quality, culturally appropriate health care.

Mary Jo Berghtol, who worked as a nurse in Fresno, California explained the confusion Hmong refugees face in understanding the differences between traditional Hmong medical practices and the complex US health care system said, “They have jumped 2,000 years in a matter of a few days.” The magnitude of this cultural transition is difficult for non-Hmong health care workers to grasp and address. This paper seeks to explain how these extremely divergent medical practices impact use of OTCs, traditional medicines and western pharmaceuticals.

The transcultural model of nursing suggests that respect of the patient’s own culture is critical for all patients with the quality care that the US health care system can deliver. As a pioneering nurse theorist, Madeline Leninger recognized that lack of knowledge of culture was a “missing link” for nurses to understand how to tailor patient care to increase adherence, healing and patient wellness.

<table>
<thead>
<tr>
<th>Drug Use</th>
<th>Prescription drug use N (%)</th>
<th>O-T-C drug use N (%)</th>
<th>Complimentary drug use N (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was the last time you took prescription/OTC/complementary-herbal drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 1 year ago</td>
<td>47 (54.65)</td>
<td>49 (74.24)</td>
<td>29 (72.50)</td>
<td>0.0232</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>30 (45.35)</td>
<td>17 (25.76)</td>
<td>11 (27.50)</td>
<td></td>
</tr>
<tr>
<td>Why did you use prescription/OTC/complementary drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest/back/neck pain</td>
<td>38 (66.67)</td>
<td>35 (72.92)</td>
<td>10 (33.33)</td>
<td>0.0013*</td>
</tr>
<tr>
<td>Hypertension/stomach/intestinal/other illness</td>
<td>19 (33.33)</td>
<td>13 (27.08)</td>
<td>20 (66.67)</td>
<td></td>
</tr>
<tr>
<td>Did prescription/OTC/complementary drugs treat most of your symptom?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not help at all</td>
<td>12 (15.38)</td>
<td>7 (6.60)</td>
<td>31 (29.52)</td>
<td>0.0001*</td>
</tr>
<tr>
<td>Very helpful/ helps a lot</td>
<td>66 (84.62)</td>
<td>99 (93.40)</td>
<td>74 (70.48)</td>
<td></td>
</tr>
<tr>
<td>How important for you to use prescription/OTC/complementary drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not/modest important</td>
<td>14 (13.33)</td>
<td>12 (11.32)</td>
<td>28 (26.67)</td>
<td>0.0057*</td>
</tr>
<tr>
<td>Somewhat/very important</td>
<td>91 (86.67)</td>
<td>94 (88.68)</td>
<td>77 (73.33)</td>
<td></td>
</tr>
<tr>
<td>Prescription/OTC/complementary drugs are something</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive/helpful</td>
<td>83 (87.37)</td>
<td>72 (74.23)</td>
<td>46 (52.87)</td>
<td>0.0001*</td>
</tr>
<tr>
<td>Negative/danger/ evil</td>
<td>12 (12.63)</td>
<td>25 (25.77)</td>
<td>41 (47.13)</td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Use of prescription, OTC, and complimentary medication use.

References:

8. Leninger M Madeline Leniger’s cultural care: diversity and universality theory.

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