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Litigious Events Involving Case Managers - Legal Concerns in Case Management
Marcella F. Jones, BSN, RN and Jamesetta Halley-Boyce, PhD, RN, FACHE

Summary

It is often said we live in a highly litigious environment. Litigation is increasing within our society. Some of the litigation is frivolous while other cases have merit. The intent of this article is to bring the real prospect of being named in civil litigation to the direct attention of the advanced practice case management professional, registered, professional nurses. The duality in functioning in the case management profession and upholding the ethical and professional standards of nursing is a challenging one, yet it is expected, even demanded. The purpose of this manuscript is to illustrate the frequency in which case management nurses are sued by patients and to identify those scenarios in which litigation may occur with increased regularity. An examination of areas where nurses are employed in this role include insurance reimbursement groups, acute and sub-acute care centers and within the realm of workers compensation claims.

Key Points

- Guidance and advice was sought from experienced nurse attorneys and malpractice lawyers and disseminated throughout this review. Expanded guidance regarding the role of the advanced practice nurse (APN) was also obtained from several leading nursing associations who contribute to the advancement of nursing practice.
- Conclusions from this review indicate that most nurses practicing in the case manager role were found liable in those legal cases in which they were named defendants. It is our belief that more knowledge in the area of potential litigation will increase the awareness of case management nurses, and hopefully all nurses, to ensure throughout their careers the delivery of care that is safe, therapeutic, compassionate, cost effective and free of litigious events.

INTRODUCTION

Investigating legal issues within the realm of case management is an important and robust issue that needs to be included in the core study of this discipline. Over the last five years, medical malpractice claims against registered nurses have increased in a variety of disciplines. The reasons vary in the root cause of why there has been such a dramatic rise in lawsuits with registered nurses being named as defendants. In some instances, the cause has been attributed to higher patient workloads that increase the risk of errors, increased delegation of tasks to other less prepared parties, the complexity of proving malpractice claims against physicians in non-fatal cases, and the expansion into advanced practice within nursing.1

All five causes identified as possible aggravating factors in this phenomenon can be applied to the functional and theoretical role of an RN case manager. The most frequent legal basis for grounds in litigation against the RN include failure to assess and monitor a patient’s condition. This is followed by failure to comply with standards of care required by the hospital or state board of nursing; failure to use medical equipment in a knowledgeable or responsible manner; failure to document a patient’s condition; failure to act as a patient advocate and failure to communicate a patient’s complaints to a doctor in a timely fashion.1

All of these six most commonly identified grounds for legal action against a nurse are seen in the work performed by case managers. It is important to have clarity when performing and considering the role of an RN case manager. Although the case manager role may no longer involve the delivery of actual skilled nursing care, it requires the consistent application of skilled nursing judgement in the construction of care delivery. In this context, the RN case manager functions in an advanced practice role, therefore increasing the risk of exposure to legal claims. “Case management is an important strategy and advanced practice in nursing because it seeks to coordinate care while also reducing health care costs and ensuring patients’ quality of care.”2

LIABILITY

The RN case manager always runs the risk of stepping out of the capacity of their employment role. The employment role is defined by the employer and may or may not utilize all of the skills that the RN case manager may have. Knowing one’s limitations in the employment role is a successful strategy to ensuring that counsel will be provided by the employer in the event of litigation. Considering that legal protection is not blanketet in the terms
the employment relationship, maintaining adequate malpractice insurance is a responsible idea for any advanced practice nurse; in any specialty. Nurses often underestimate the risk that a lawsuit poses to their financial well-being if they are underinsured or not insured at all. Safe, responsible, and prudent practice does not minimize the risk of being sued by a patient. These actions ensure that your case may be presented and brought to trial if necessary and won with the nurse as the prevailing defendant. “Even if a case manager is not found liable or if the judge dismisses the case manager as a defendant before the trial occurs, the attorney fees are likely to be substantial.”

Insurance products for nurses are often of a minimal cost in comparison with the earning potential of the license granted to registered nurses. What the insurance policy guarantees is the right to fair and objective legal counsel, who solely advocates for the registered nurse. Attorneys cannot advocate or defend poor nursing practice or documentation, but they will provide advice on the best approach to mitigating the effects of a lawsuit. “If a case manager has personal malpractice insurance and someone files a claim, the insurer will assign legal counsel who owes allegiance only to the case manager….you will have legal counsel who is solidly in your corner who can, if necessary, counter arguments made by your employer’s insurer that your employer’s policy should not cover you.”

Some cases require the RN case manager to view their conduct in terms of legal protection before any relationship even commences. This is particularly true in workers’ compensation cases where there have been high rates of litigation against the RN case manager. “In workers’ compensation, the injured person may have an attorney and is already thinking about additional lawsuits. It’s not just a benign situation where you try to get them back to work. It’s fraught with emotion, and the potential for legal action against the case manager is never far away.”

The literature states that most lawsuits involving RN case managers are settled before trial and their verdict sealed. This implies that there are significant gaps in terms of how RN case managers perform in their respective roles, despite the legal standard in which they will be judged. Some case managers may assume that their risk is diminished since they no longer provide direct clinical care. “In the unreported case of Thomas v. Concentra, the defendant nurse case manager had been involved in a workers’ compensation case and found herself on the witness stand for seven straight hours. The allegations included the manner in which the case manager had directed care, lack of timeliness, and lack of advocacy. To establish the appropriate standard of care by which the nurse case manager would be judged, references were made to both the CCMC Code of Conduct and CMSA Standards of Practice. The verdict found that the workers’ compensation insurer and the case manager were both negligent and therefore liable. Similar issues are found in pending cases.”

**CASE MANAGEMENT STANDARDS OF CARE**

Protection against claims must first involve the identification of best practices, the standard of practice within the role. These standards of practice are not hospital or organization specific, but set by the authorities that govern accredited nursing bodies. For the RN case manager, such governance in determining the standards is established by the American Case Management Association, Commission for Case Management Certification, and the Nurse Practice Act of their state. Be advised however, failure to comply with hospital or agency policies regarding lawful actions in nursing practice may subject the RN case manager to liability in a malpractice claim.

The American Case Management Association delineates the scope of case management services into five distinct categories: education, care coordination, compliance, transition management, and utilization management. While not all RN case managers perform all of these actions, clear terms are communicated in describing the essential functions in each capacity. In clear terms, the ACMA states: “For all patients requiring active case management services, case management is expected to ensure and provide education relevant to the effective progression of care, the appropriate level of care and safe patient transition.”

**SCOPE OF PRACTICE**

Knowing the standard and scope of practice that encompasses the legal and ethical role of the RN case manager, despite the actual functionality of the role in which the RN case manager may be placed, is the pre-requisite for safe practice. It is also important to convey and clearly iterate the boundaries of the RN Case Manager in whatever capacity that is served in the present organization. Communicating the role in which you operate in the patient’s delivery of care is an important element of disclosure that assists in reducing the possibility of being named in litigation. “This may not keep case managers out of a lawsuit, but it may mitigate their role in it by showing that they attempted to inform the patient and family exactly what the case managers role is so they don’t have unrealistic expectations about case management services or expect a case manager to provide hands-on treatment” It is advised that case managers coordinate with their employers to provide printed materials to patients about the case management services that should be provided. More importantly, documentation of services provided is essential.

**THE LEGAL RECORD**

Documentation is reiterated throughout the practice of nursing as the cornerstone of legal protection. Quality documentation is what is required to protect the RN case manager because the entire role is based on the judgment of the advanced practice nurse. “Case managers can be at risk for legal action if the plan of care they develop doesn’t meet the patient’s needs, is incomplete, or if the patient is referred to a provider that cannot provide appropriate care.”

Knowing your patient’s medical, financial, and social support needs are important because they will impact the pathway that the case manager intends to direct the patient towards. “Case managers also may be liable when they fail to match patients with appropriate resources. For instance, if your patient is from a rural area with limited transportation, look at the best resources to meet his or her needs and ensure compliance based on the particular situation.” The record must be complete regarding the plan of care, services to be provided, the patient’s response to the treatment plan, refusal of services, and follow-up documentation to the interventions. “Providers also run the risk of negligence or malpractice when they fail to document the care provided.”

Refusal of services or referrals provided does not absolve the case manager from threat of liability. Recognize that the patient and case management relationship is always a collaborative
one and patients do have the right to disagree with the plan. “If
a case manager recommends a treatment plan to a patient or
suggests a particular service, it should be thoroughly documented
in the record.” 9 Key points of documentation in the record are
to respond in the written form to clients reiterating the points of
the discussion. 8 These communications serve as additional proof
that the case manager has performed their duties and attempted to
reach consensus with the patient in the shared relationship.

Patients may disagree or have plans for different medical
approaches to their care. It is important that the case manager
considers the patient’s own desires and advocates for choices
that align with the patient’s values. The patient advocate role is
essential for the case manager. 6

Patients may not always be knowledgeable about the services
that are available to them or have clear understandings of how
their coverage impacts their choices. While case managers do not
specialize in health coverage plans, being cognizant of the terms of
the health plan and available services is a requirement of effective
planning. Explaining this to patients and their families is often met
with a certain degree of resistance and productive communication
may become strained.

Patients do not always have a clear understanding of what
impact their choices will have. It is always important for the case
manager to educate and re-educate patients about the purpose of
case management services, their role in the development of a care
plan and knowledge of all available resources. Not all patients who
receive case management services are appropriate candidates for this
type of medical management. Effective case management requires
cooperation and not all patients are cooperative. Patients that refuse
treatment options, who refuse to keep scheduled appointments and
refuse to accept accountability in their health conditions pose the
most legal risk to case managers. In many cases, the patients that
need case management services the most, those with multiple co-
morbidities, may become litigants. The noncompliant patient may
create what could appear to be a void in the case management
process, creating the appearance of incompleteness in a poorly
documented record. “With noncompliant patients, there is always
the risk of a bad outcome. They aren’t taking anyone’s advice
because of their own stubbornness, but if they die, family members
look around for someone to blame, even if they understand that the
patient wasn’t doing what they were told.”

ETHICAL OBLIGATIONS

A noncompliant patient may also face termination of
services, whether case management or medicaid, by the result of
noncompliance. Noncompliant patients may miss appointments,
skip appointments, refuse providers, referrals and/or develop
patterns which are unconducive to effective care management.
These types of patients may create problems that need to be
escalated to the appropriate organizational level immediately and
conveyed with all members of the interprofessional team. Case
managers that do not clearly articulate the terms of the relationship
and what behaviors constitute severance by the patient, run the risk
of being liable for abandonment. 9

Abandonment constitutes an offense that the RN case manager
can be held legally liable for in civil penalties, and also can have
their RN license revoked in many states. For this reason, RN case
managers should be aggressive in their documentation about the
timeline of events with all patients but particularly with these types
of patients. “Clients who accuse case managers of abandonment
must prove that the case manager terminated the relationship
unilaterally, without reasonable notice, and when further attention
was required.”

Noncompliant patients as described must be aware that their
behaviors may constitute termination of the relationship from either
side, and interventions must be presented to address the cause of
noncompliance. RN case managers should be documenting their
conversations and communication with the patient in written form
as well. “Any time you veer away from objective reporting, you
could be putting yourself in personal jeopardy… Make sure that
your documentation is objective with no personal comments, she
cautions. For instance, even if you don’t believe the person is telling
you the truth, don’t put it down on paper.” 74 Adding subjective
statements about the causes of noncompliance, or language that
suggests that the writer has developed personal opinions about the
patient, may be viewed negatively in a court of law.

When the client’s behavior dictates termination, the RN case
manager must afford the patient every opportunity to correct the
trajectory of the relationship, even if expending the energy or
resources to do so may not bear meaningful results. It is in these
encounters that the RN case manager must remain clear, concise,
and only state the facts that have occurred during interaction
with the patient. Communication with the physician regarding
noncompliance is also a measure that must be documented
throughout the medical record. “Good communication with
physicians and other health care providers as well as clients is
essential in helping case managers avoid liability.”

Termination can also take place because patients may lose
their benefits or insurance coverage while active case management
services are being provided. How these terminations are conducted
constitute whether or not the RN case manager has acted
appropriately in the severance of care. This type of encounter with
patients may present emotional and ethical challenges, but do not
place the RN case manager in legal danger if the appropriate steps
are followed. While not required, the RN case manager should
give the patient the information for obtaining low-cost or state
funded insurance.

APPLICATION OF CASE MANAGEMENT IN
INDUSTRY

Different types of employment settings often impact the work
that RN case managers perform. Case managers and the model
of case management are being applied to more settings across
a larger range of industries, and has shown to be effective in the
conservation of financial resources. “In these economic times, case
managers are well advised to look at a broad area of practice and
expand their opportunities by matching their skills with the products
the market desires….in addition to case management, consider
file review or legal nurse work.” 12 Healthcare organizations,
government agencies, and insurance companies generally employ
case managers. The success of such models has allowed some
case managers to operate in the realm of private practice. Case
managers do have the flexibility to operate independently and
do not need to work under a physician to provide services. Case
managers have the experience and knowledge of appropriate care
plans and often work within legal settings reviewing medical
charts. Case management could be considered as an entryway into
the realm of legal nursing. Experienced RN case managers could
be called as expert witnesses at trials, as consultants for specific issues related to public policy, or influential in the determination of insurance products.  

THE EXPERT WITNESS

When an RN case manager is included in litigation or named as the defendant, another RN case manager must evaluate the conduct of the care performed. “It is not enough that the CMSA has printed the “standards.” A case manager, available for live testimony, would be required to give his or her opinion, through a report, perhaps at deposition and ultimately at trial, as to the application of the standard to the facts of the particular case…”

This RN case manager, testifying as the expert witness, must be able to demonstrate the appropriate level of education on the subject matter, have substantial experience within the field of testimony, and be able to objectively report only on the facts and actions that are generally undertaken by the diligent case manager. “An expert witness is only as good as his or her education and experience in two critical ways: the first is establishing and maintaining credibility by having expertise in the required field, and the second is withstanding cross-examination.” The judicial requirements for who is considered an expert witness may vary from state to state, but are based on these principles.

ADVOCACY AND EDUCATION

RN case managers employed by a reimbursement source, i.e., Managed Care Company, must balance the needs of patient advocacy with the shared cost saving goals of their respective employer. A high standard of ethical behavior must be maintained within this relationship. Always disclose to the patient that you are working on behalf of the reimbursement source to provide adequate and cost effective care. Most RN case managers named in litigation are often cited for failure to advocate for the patient. No matter what the role may constitute, an active RN license requires that you continue to maintain the ethical standards required of the profession.

The patient may be unaware that you, the case manager, must balance between the need to provide appropriate care to the patient and the most cost effective delivery from the insurers’ perspective. Patients may request certain treatments that have no value to their care or are not cost effective in terms of the outcome.

Educating the client on the treatments proposed, alternatives available, and what their benefit plans cover is the first step in advocacy. The RN case manager should be diverting patients away from utilizing their resources in unproductive ways, but not because they solely intend to produce more cost savings for the employer. The most common area of liability appears to be in those cases where case managers make decisions based on cost-savings alone, without regard to quality.

Explaining the rationale for why certain treatments are not appropriate is key to protection from frivolous claims levied by patients. Explanations, documentation, and responses to the proposed alternatives all constitute the standard.

When alternatives have been explored and the patient is still requesting additional services, the RN case manager must seriously consider the requests of the patient and family. Balancing financial responsibility and patient advocacy are the core constructs of the decision. Not presenting or availing treatment options based on cost is not an acceptable reason for dereliction of duty no matter what the financial goals of the organization. While the RN case manager does operate with autonomy, based on their experience and judgment there are legitimate avenues for further inquiry into a patient’s request for costly treatment options. This is especially important when patients appeal decisions related to services or discharge from facilities.

DIVERSITY IN THE ROLE AND APPLICATION OF CASE MANAGEMENT MODEL

The RN case manager who operates from the provider perspective delivering clinical services faces unique legal challenges related to their assessment of need for continued service. This arena of case management focuses on determining the care that patients need and when they are appropriate for discharge or transfer to varying levels of care. “Case managers may be liable for negligence because they owe a duty to the patients to develop and implement an appropriate plan of care for patients according to Medicare Conditions of Participation and other standards of case management. They may breach this duty when they refer patients who still need acute care to home care providers.”

“Inadequate discharge planning is an area of great concern and the subject of several suits. No matter what the hospital or other facility calls the case manager, the functions that are required are essential functions of the role of the case manager.” While acute care organizations push for decreased lengths of stay during the admission period, case managers must be advocating and creating safe discharge plans for the patients that receive these services.

Cesta (2017) states, “To maintain financial viability, acute care settings must shorten the number of inpatient hospital days. Whether the reimbursement system is negotiated managed care or the prospective payment system, length of stay can translate to financial success or failure for any hospital in today’s healthcare environment.”

The role of the RN case manager is essential in today’s healthcare reform environment. Decisions with increased financial considerations must be made in collaboration with social workers when the patient presents with unique financial or social problems that compound the issue of being safely discharged into the community. Many RN case managers have relied on the service of home health agencies to meet the goals related to decreasing the length of stay at the hospital. Home health agencies now specialize in many arenas of skilled nursing, and advancements in technology have brought many medical devices into the home setting. Yet, this is not always a productive discharge plan and may result in a readmission within the 30 day window.

Ensuring that all roles are fulfilled under the umbrella is difficult since each component of case management is distinct. “The difference between doing utilization review and discharge planning is pretty clear. Utilization review determines if the patient meets the criteria for discharge, and discharge planning determines the next appropriate level of care.” Focusing on the development of a care plan based on what resources the patient has may create risk of liability for the nurse case manager. Although the request for additional care/services may be denied, the RN case manager should still apply and appeal for these services based on medical necessity. By following this process, the RN case manager ensures that her duty to the patient has been fulfilled and if the patient pursues litigation, the nurse can feel a level of legal comfort.

The construction of the discharge plan is made from the results
of those efforts. With all of the comorbidities patients face and the increased life span of humans today, care options and the levels of care have increased. A case manager must be educated on what constitutes acute care levels of service and which patients actually meet the criteria.

**CONCLUSION**

The literature states that most lawsuits involving RN case managers are settled before trial and their verdict sealed. This implies that there are significant gaps in terms of how RN case managers perform in their respective roles, despite the legal standard in which they will be judged. Some case managers may assume that their risk is diminished since they no longer provide direct clinical care. “In the unreported case of Thomas v. Concentra, the defendant, nurse case manager had been involved in a workers compensation case and found herself on the witness stand for seven straight hours. The allegations included the manner in which the case manager had directed care, lack of timeliness, and lack of advocacy. To establish the appropriate standard of care by which the nurse case manager would be judged, references were made to both The CCMC Code of Conduct and CMSA Standards of Practice. The verdict found that the workers compensation insurer and the case manager were both negligent and therefore liable. Similar issues are found in pending cases.”

Case management from the perspective of the registered nurse is an advanced practice role which deserves that recognition. Case managers should define their roles in a way that reflects the risks that are undertaken. Balancing ethical standards and multiple conflicting interests is what makes the case management role unique from other areas of advanced practice. Having clearly defined roles protects the RN case manager from litigation. As case management defines and redefines how healthcare is delivered throughout the nation, it would be best that the leaders in this field shape the scope of this role in any setting, establish care maps and other tools to ensure consistency of application and to strengthen the case manager’s position when faced with litigation.

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AAMCN encourages the use of legal counsel advice in any situation in which a legal concern arises. This article is not to be used as legal advice.

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Becoming an Agent for Change in an Ever-Changing Healthcare Environment
Felizitas Devine, RN, MS, MBA, CCM, CMHCN, Koen Brown, BSN, MSN, RN, CCM, CMHCN, and John Socolofsky

Summary
The healthcare ecosystem is constantly changing and at an increasing pace. How we as healthcare professionals react to the changes can impact our professional success and personal satisfaction. Supporting change by becoming a change agent can be a great way to adapt to change and positively impact your organization and possibly your career.

Key Points
• The process of becoming a change agent involves characteristics and tactics that can be acquired through practice. The skills acquired through this practice should not only help you succeed professionally, but also have a greater personal satisfaction with your work and life.

IT’S NO BREAKING NEWS THAT THE HEALTHCARE ecosystem is changing. Whether it be due to regulations that govern our work, competitive pressures, emerging business models, evolving member demographics, or technology, change is all around us. Not only is change happening whether we like it or not, the pace of change seems to be accelerating. As healthcare professionals, how can we best position ourselves to adapt to the changes impacting our work and members we serve?

WHAT IS “CHANGE?”
The word “change” is used so often and in so many contexts that we can easily become numb to it. A dictionary would define change as “to make different in some particular” or “to make radically different.” Both of those nuances certainly apply to change in healthcare. Some changes impact one facet of our job, for example, alteration of a work process we’ve used for years. Other changes can be more radical, such as our organization being acquired by another company. How we respond to change can significantly impact our position in our organization, our job satisfaction, and the value of our work.

Many still consider one of the first conceptual models of organizational change accurate today. The model involves three steps:
• Unfreezing: The status quo is disturbed by some disruptive force.
• Moving: Change occurs, and behavior moves to a different level.
• Freezing: Unless there are steps taken to institutionalize the new status quo, behavior can regress to the old level.

In healthcare, disruptive forces may include:
• Regulation: The Patient Protection and Affordable Care Act (ACA) has introduced many changes to the work of healthcare professionals.
• Demographics: One significant disruptive force is the growing Medicare population – over 55 million Medicare beneficiaries, and growing at more than 1 million per year.
• New Healthcare Models: Accountable Care Organizations, Patient Centered Medical Homes, Demonstration projects, and a focus on Population Health have all introduced change.
• Value-Based Care: The financial shift from fee-for-service to value-based care will continue to drive significant change.
• Technology: The surge in technological advances can seem overwhelming, from introductions of new Electronic Health Records systems to the increasing use of data and analytics in healthcare.
• Political Uncertainty: Since health regulations ebb and flow with the political forces that create the regulations, there is always a level of uncertainty in the future.

All of this boils down to you: Are you ready for change? What reaction will you have to change? What role will you play in your organization’s inevitable change?

REACTIONS TO CHANGE
There are positive and negative reactions to change.
Negative:
• Resistance can take the form of passive-aggressive...
subterfuge or active rebellion.

- Resignation can involve saying, “Whatever... I’ll just keep doing my job and endure what happens,” or can mean actually resigning – quitting in the face of impending change.

Positive:

- Seeing change as a challenge and adopting it willingly can mean learning new things, embarking on a new career path, and making oneself more valuable to the organization.
- Becoming a change agent means not only adapting to the change yourself, but capturing the organizational vision driving the change and helping others adapt.

CHARACTERISTICS OF CHANGE AGENTS

We are hoping you want to become a change agent. Change agents typically share some or all of the following characteristics:

- Extroverted: Change agents work their network, participate in social media, show initiative, and are outgoing. Caveat: You can be a change agent even if you consider yourself an introvert. All of these behaviors can be learned and practiced.
- Good Communicators: Change agents exhibit strong interpersonal skills, both through verbal and written communication.
- Facilitators: Change agents are leaders, either informally through being a role model, or formally, by mentoring and evangelizing others.
- Creative: Change agents can think outside the box, envisioning upstream and downstream opportunities and risks.
- Trustworthy: Change agents build trust through consistent, reliable performance and a proactive, communicative attitude. They create an environment for success without needing to control the process. They inspire hope and not fear and maintain their credibility with honesty and hard work.
- Takes Risks: Change agents are not willing to settle for the status quo but push the boundary to achieve the organization’s vision. They are not afraid of failure but accept it as a part of growth and move on.
- Good Organizers: Change agents typically have good organizational skills in their personal lives and as leaders.
- Visionary: Change agents are good at creating a vision and seeing actions and reactions in a strategic context.
- Accessible: Change agents remain approachable regardless of level. They make time for those they lead and interact with.
- Data-Savvy: Change agents use data and analytics to baseline and set and monitor progress toward goals, enabling decision making based on fact vs. feelings.

BECOMING A CHANGE AGENT

So how does one become a change agent? Practice, practice, practice. Many of the characteristics of being a change agent are not natural for most of us. But there are techniques you can practice that will improve your ability to adapt to and embrace (and maybe lead) change:

- Grieve: It’s ok to grieve what used to be, but then we need to let it go. Stages of grief include denial, anger, bargaining, depression and acceptance. Go ahead and reminisce about how things used to be, but proactively move on. Get over it. The change is going to happen and it would be better for you to be on board and supportive.
- Control Your Emotions: Outbursts, talking out loud, or gossip may not be to your benefit.
- Expect Change: Change is constant and is going to happen. Be observant and don’t get caught off guard.
- Set Goals: Set a new personal goal – your previous direction may no longer be possible.
- Work Your Network: Build a strong internal and external network and leverage it to get an outside perspective. Talk it through with someone who isn’t personally affected.

TACTICAL STEPS TO DEALING WITH CHANGE

Keeping yourself current and relevant is always good for your career, especially in a climate of pervasive change. Part of making yourself relevant is having options outside of your current situation. Making yourself relevant makes you more valuable to your current organization, plus it improves your opportunities if you decide to move on. The following practices should be part of your regular routine:

- Resume: Keep it updated. Keep your resume clear, succinct, relevant, and demonstrating continuous development. Post it on Monster, Indeed, CareerBuilder, and applicable professional organization sites.
- Social Media: Participate. Start with “liking” what others are posting but move toward asserting your own opinions and writing posts.
- Publications: Write them. Find a topic you are passionate about, or at least mildly interested in, and write an article for a peer-reviewed journal or for publication on LinkedIn. If your writing skills are not strong, find a partner to write with.
- Presentations and Posters: Present. Being in front of people and discussing current topics is a great way for you to be seen as a leader and change agent.
- Professional Organizations: Participate and volunteer. There is no end to the need within healthcare professional organizations for volunteers. Not only is this a great boost for your resume, it is a great way to lead by serving.
- Continuous Growth: Demonstrate it. Football coach Lou Holtz is credited with saying, “In this world you’re either growing or you’re dying so get in motion and grow.” Make it a goal to add one significant achievement to your resume each quarter. Be it a publication, a certification, a course, pursuing an advanced degree, or a client experience.

SUMMARY

In healthcare and in life, we all experience, and at times are overwhelmed by change. We can run and hide, and maybe survive for a while, but becoming an agent of change is a better long-term option. Make yourself adaptable and even able to lead change in your organization. It will help you not only succeed professionally, but also have a greater personal satisfaction with your work and life.
Felizitas Devine, RN, MS, MBA, CCM, CMCN, Koen Brown, BSN, MSN, RN, CCM, CMCN and John Socolofsky are all health care consultants.

REFERENCES

It’s our turn to pick up where you’ve left off.

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Preparing Nursing Students for Care Coordination Practice
Crystal DeVance-Wilson, PhD(c), MBA, MS, PH-CNS-BC and Patricia Zimberg, JD, MS, RN

Summary

New models of health care delivery, managed care oversight and government regulation have increased the need for highly skilled care coordinators. Hospitals, health systems and insurers recognize the importance of care coordination as a valuable strategy to achieve the triple aim of improving health outcomes, quality of care and lowering costs. It is critical that employers, service providers and educators work together to ensure nurses are prepared for the demands of the current healthcare environment.

Although care coordination is not a new practice, the emphasis on interprofessional practice, the use of data and technology, and outcomes-driven-care are driving the need for nurses who have a strong understanding of the care coordination process. Schools of nursing, in collaboration with healthcare organizations and other key stakeholders, are well positioned to prepare nursing students for the care coordinator role.

Key Points

- The demands of the current healthcare environment require highly skilled nurse care coordinators.
- Nursing students must be prepared with knowledge, skills and attitudes in the key areas of 1) patient and family centered care, 2) the use of technology for patient care delivery and to measure and evaluate quality and outcomes, 3) health insurance and reimbursement, and 4) leading effective interprofessional teams.
- Nursing schools, healthcare organizations and key stakeholders must work to better prepare nursing students for the challenges of today’s healthcare environment.

INTRODUCTION

The Nursing Scope and Standards of Practice and the nursing education curriculum essentials enumerate the expectations of nursing students at the baccalaureate, masters and doctoral (doctors of nursing practice) levels for care coordination. To ensure registered nurses have the knowledge, skills and attitudes necessary for the role of nurse care coordination, plans of study should place greater emphasis and/or include content that cover, 1) patient and family centered care delivery, 2) the use of technology for patient care delivery and to measure and evaluate quality and outcomes, 3) health insurance and reimbursement, and 4) leading effective interprofessional teams. The purpose of this commentary is to describe key content in nursing education to support the practice of nurse care coordination.

BACKGROUND

Chronic disease is the leading cause of death and disability in the United States. An estimated 157 million Americans will have a chronic disease by the year 2020. The five most costly and preventable chronic conditions cost the US economy approximately $347 billion dollars annually in treatment and lost productivity. Care fragmentation is a significant driver of high health care costs and poor health outcomes. High levels of care fragmentation result in higher rates of preventable hospitalization, poor quality of care and increased cost to patients. Improved care coordination, which includes case management and care transitions, is one answer to this persistent and growing problem.

Care coordination is not a new practice phenomenon. Early efforts focused on providing care for the poor, chronically ill and containing costs through the coordination of services within the public health sector. Nurses have played a pivotal role in care coordination which is identified by the Institute of Medicine (IOM) “as one of the traditional strengths of the nursing profession whether in the community or the acute care setting”. Over the past 18 years, care coordination has reemerged as an important mechanism for achieving the triple aim of improving health care quality, patient outcomes and reducing the cost of health care. The proliferation of care coordination services in the health care system warrants a similar emphasis on care coordination in nursing education.
**PROFESSIONAL COMPETENCIES**

For the purpose of this discussion, four educational focus areas were identified based on the competencies developed by the American Nurses Association’s (ANA) Nursing: Scope and Standards of Practice\(^1\) and the Care Coordination and Transitions Management Core Curriculum (CCTM).\(^8\) Also considered were the American Association of Colleges of Nursing (AACN) Baccalaureate Essentials, which explicitly acknowledge the importance of care coordination in Essential II, Basic Organizational and Systems Leadership for Quality Care and Patient Safety and Essential IV, Information Management and Application of Patient Care Technology. The competencies and essentials are also closely aligned with the Quality and Safety Education for Nursing (QSEN), Interprofessional Education Collaborative (IPEC) and the Public Health Nursing Core Competencies.

The education focus areas for care coordination are 1) patient and family centered care delivery, 2) the use of technology for patient care delivery and measurement and evaluation of quality and outcomes, 3) effective interprofessional teams, 4) health insurance and reimbursement methods. Table 1 depicts the focus areas in relation to the ANA Scope and Standards and CCTM competencies.

**PATIENT AND FAMILY CENTERED CARE**

Patient centered care is defined by QSEN, as “the recognition by the healthcare provider of the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values and needs”\(^9\). Patient and family centered care is one of six aims for improvement described in the IOM report, “Crossing the Quality

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**Table 1: Nurse Care Coordination Education Foci aligned with the ANA Scope and Standards of Practice and CCTM Core Curriculum**

<table>
<thead>
<tr>
<th>Nurse Care Coordination Education Focus Areas</th>
<th>ANA: Scope and Standards of Practice(^1)</th>
<th>Care Coordination and Transitions Management Core Curriculum(^8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Family Centered Care</td>
<td>• Organization of care plan components</td>
<td>• Support self-care management</td>
</tr>
<tr>
<td></td>
<td>• Management of healthcare consumers’ care to maximize independence and quality of life</td>
<td>• Education and engagement of patient and family</td>
</tr>
<tr>
<td></td>
<td>• Assistance to healthcare consumers in identifying care options</td>
<td>• Cross setting communication and transition</td>
</tr>
<tr>
<td></td>
<td>• Communication with the healthcare consumer, family and members of the healthcare system especially during transitions</td>
<td>• Coaching and counseling of patients and families</td>
</tr>
<tr>
<td></td>
<td>• Advocacy for delivery of dignified care by the interprofessional team</td>
<td>• Nursing process</td>
</tr>
<tr>
<td>Use of Technology for Patient Care Delivery and Measurement of Outcomes</td>
<td>• Communication with healthcare consumer, family and members of the healthcare system especially during transitions</td>
<td>• Patient centered planning</td>
</tr>
<tr>
<td></td>
<td>• Documentation of coordination of care</td>
<td>• Population health management</td>
</tr>
<tr>
<td></td>
<td>• Synthesis of data and information to prescribe necessary system and community support measures</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>Effective Interprofessional Teams</td>
<td>• Advocacy for delivery of dignified care by the interprofessional team</td>
<td>• Telehealth</td>
</tr>
<tr>
<td></td>
<td>• Leadership in the coordination of interprofessional healthcare for integrated delivery of healthcare services</td>
<td></td>
</tr>
<tr>
<td>Healthcare Finance, Reimbursement, Regulation and Policy</td>
<td>• Synthesis of data and information to prescribe necessary system and community support measures</td>
<td>• Nursing process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Population health management</td>
</tr>
</tbody>
</table>

\(^1\) ANA: Nursing: Scope and Standards of Practice
\(^8\) CCTM: Care Coordination and Transitions Management Core Curriculum

\(^9\) IOM:-crossing the quality chasm
Patient outcomes, establishing quality indicators, analyzing risk transitions, patient and population care delivery, benchmarking facilitate complex communication exchanges with healthcare and educational resources, healthcare equipment, diagnostic tools), efficiencies in patient care delivery (i.e., patient and provider populations. HIT also improves the quality of care by increasing making and quality improvements for individual patients and including patients and providers, stores data used for decision-supports communication between members of the healthcare team.

Chasm”. The Patient and Family Centered Care describes it as an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families.

Patient and family centered care is considered a core value of most health care organizations and until recently, one of the least understood and poorly implemented. Optimizing the patient and family experience has historically been viewed as nice to have but not a fundamental aspect of a health care organization’s attention. With the increased attention to Hospital Consumer Assessments of Healthcare Providers and Systems (HCAHPS) and calls from advocacy organizations, patients and families for better quality treatment, healthcare organizations are revisiting their approaches to patient and family centered care in an effort to improve patient outcomes and patient satisfaction. If patient-clinician relationships are not being developed, patients are not learning more about their health and how to care for themselves, and patient morbidity and mortality continues to rise, cutting edge technologies, warm greetings and fancy amenities are meaningless.

Patient and family centered care has been shown to improve health outcomes, and decrease health care utilization, healthcare costs and improve patient satisfaction. For this reason, it is important that nursing students at all levels have the knowledge, skills and attitudes needed for them to effectively practice patient and family centered care. Nursing programs teach many skills for implementing patient and family centered care and must ensure the skills are reinforced throughout the programs. Additionally, cognitive and psychomotor skills must be overlaid with affective skills. Some of the skills identified by the Institute for Healthcare Improvement (IHI) and considered emblematic of patient and family centered care include demonstrating respect for patients’ preferences and opinions, relationship building, empathy and social support. These skills are best learned through practice in simulation and practicum where instructors can model behaviors and students have the opportunity to demonstrate and receive immediate feedback.

HEALTH INFORMATION TECHNOLOGY AND CARE COORDINATION
Health information technology is a repository for patient information that increases efficiencies in care coordination service delivery. Health information technology (HIT) makes information “accessible, actionable, timely, customizable, and portable”. It supports communication between members of the healthcare team including patients and providers, stores data used for decision-making and quality improvements for individual patients and populations. HIT also improves the quality of care by increasing efficiencies in patient care delivery (i.e., patient and provider educational resources, healthcare equipment, diagnostic tools), preventing medical errors and decreasing duplication of services.

Informatics is an essential nursing education competency and supports students in the delivery of safe patient care, data generation, compilation and analysis, research, regulatory, legal and ethical concerns. Nurse care coordinators use HIT to facilitate complex communication exchanges with healthcare and service providers, patients and families and coordinating care transitions, patient and population care delivery, benchmarking patient outcomes, establishing quality indicators, analyzing risk and resource utilization. Upon graduation, nurses may not be prepared for the rigorous use of HIT required by nurses practicing care coordination.

Increasingly, nurse care coordinators are using telehealth to interface with patients remotely. Tele-home monitoring, face-to-face tele-visits, and communicating through patient portals are some examples of new and emerging technologies in use by nurse care coordinators. Developing opportunities for nursing students to explore new and emerging technologies is essential for increasing readiness for care coordination roles.

An imperative for nursing education is to prepare students for leadership roles in care coordination. Students will soon be in positions to resolve the health information technology issues we are currently experiencing. Building skills in healthcare policy and advocacy would prepare future leaders to address the gaps in the care coordination infrastructure including, creating measures for care coordination activities, creating mechanisms for improved communication between and within organizations, specialties and patients, and driving healthcare policy as it pertains to efforts to improve care coordination. In doing so, we create opportunities for new knowledge about care coordination practice, education and research.

INTERPROFESSIONAL TEAMWORK
According to the IOM, diverse professionals working together will result in improved communication, improved patient outcomes and efficient use of resources. Interprofessional collaboration is considered a critical component of every successful care coordination model, which not only includes the perspective of healthcare providers and allied professionals but also those of patients, families and caregivers. To that end, nursing students at every level are required to participate in interprofessional education (IPE) with demonstrated competency.

The level of adoption of IPE programs by nursing schools is unclear however, factors such as faculty workload, identifying adequate IPE opportunities, faculty development, and ironically, coordinating with multiple disciplines including many new healthcare roles, are noted barriers to implementation. Developing IPE activities requires a great deal of coordination and effort. Schools are working diligently to develop meaningful programs. Nurse care coordinators will be expected to work collaboratively with various professions and will often be expected to lead the health care team. While a great deal of progress has been made in the development of IPE activities and programs, nursing and other health professions must continue the effort to create strong IPE programs. Some recommendations for building strong programs include providing adequate financial, space and human resources, creating common calendars to facilitate scheduling, and value interprofessional education by leadership and faculty.

HEALTH INSURANCE AND REIMBURSEMENT
Nurses in most specialties are not required to know much about health insurance and reimbursement. Nurse care coordinators in their roles as advocates, coaches and counselors, need more than a basic understanding of health insurance and reimbursements to lead successful programs. An expectation of nurse care coordinators is to support patients by linking them to quality and affordable services. In order to do so, nurse care coordinators must be aware of the various types of insurance, which services are covered, and how the costs of co-payments and deductibles
affect the provision of services. Nurses may not handle the day-to-day business of insurance, although some do, but they should have enough information to provide sound guidance to patients.

Insurance and reimbursement go hand and hand. The type of insurance dictates the organizations or providers’ reimbursement. Healthcare organizations and providers rely on the funding generated from reimbursements to support the activities of care delivery and for this reason, the nurse care coordinator in the role of leader and patient advocate requires a good understanding of traditional reimbursements models and newer models including, value-based purchasing and alternative payment models. Students may not be proficient at health insurance and reimbursement when they graduate but should have a strong basic understanding of these basic healthcare finance concepts.

CONCLUSION

There has been a paradigm shift in healthcare and nurses must change as well. Successful nurse care coordinators possess the knowledge, skills and attitudes to meet the challenges of the current healthcare environment. Schools of nursing in partnership with healthcare organizations and other stakeholders are positioned to facilitate better student preparation in the key focus areas of patient and family centered care, the use of technology beyond the bedside, leading interdisciplinary teams, health insurance, and reimbursement throughout the curriculum.

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Prescription Drug Coverage for Treatment of Low Back Pain Among US Medicaid, Medicare Advantage, and Commercial Insurers

Dora H. Lin, MHS, Christopher M. Jones, PharmD, MPH, and Wilson M. Compton, MD, MPE

Summary

Despite unprecedented injuries and deaths from prescription opioids, little is known regarding medication coverage policies for the treatment of chronic noncancer pain among US insurers. This article consists of a cross-sectional study of health plan documents from 15 Medicaid, 15 Medicare Advantage, and 20 commercial health plans in 2017 from 16 US states representing more than half the US population and 20 interviews with more than 43 senior medical and pharmacy health plan executives from representative plans. Data analysis was conducted from April 2017 to January 2018. Given the effect of coverage policies on drug utilization and health outcomes, these findings provide an important opportunity to evaluate how formulary placement, utilization management, copayments, and integration of nonpharmacologic treatments can be optimized to improve pain care while reducing opioid-related injuries and deaths.

Key Points

- In this cross-sectional study of 62 products used to treat low back pain examined across 50 Medicaid, Medicare Advantage, and commercial insurance plans, utilization management strategies were common for nonopioids and opioids alike.
- Key informant interviews with plan executives underscored the frequent absence of comprehensive strategies to improve chronic pain treatment and to better integrate pharmacologic and nonpharmacologic opioid alternatives.

INTRODUCTION

Between 1999 and 2010, opioid-related overdose deaths rose markedly in parallel with the increased prescribing of opioids in the United States, reaching a total of 42,249 deaths in 2016. An estimated 25 million Americans experience pain every day, often significantly interfering with daily activities. Many experts as well as recent projections suggest that the rates of injuries and deaths from opioids will continue to increase in the near term, underscoring the urgency for comprehensive, coordinated interventions focused on improving pain care and reducing opioid-related harms.

The Centers for Disease Control and Prevention guidelines for prescribing opioids for chronic pain and the clinical practice guidelines for low back pain set forth evidence-based recommendations and promote use of nonopioid therapies as first-line treatment for chronic pain. The National Pain Strategy calls for a multipronged approach to provide integrated care to treat chronic pain. It also highlights the need to improve coverage and reimbursement policies, because these policies play an important role in shaping drug utilization. Despite this, little is known regarding how public and private payers have designed coverage policies for opioids and other treatments for chronic noncancer pain. One recent study examined utilization management over the past decade and found that Medicare Part D formularies increasingly used quantity limits and, to a lesser degree, prior authorization to restrict opioid prescribing. Others have highlighted coverage gaps for opioid use disorder treatment and its potential unintended consequences. However, the persistent information gap regarding coverage of chronic noncancer pain treatments constrains the ability of decision makers to develop informed policies.

We evaluated the 2017 coverage policies of a diverse group of Medicaid, Medicare Advantage, and commercial health plans. We focused on 62 pharmacologic treatments for low back pain because it is one of the most common causes of chronic pain and one of the conditions for which prescription opioids have been commonly overused despite an unfavorable risk-benefit profile. We supplemented our data analysis with 20 key informant interviews with medical and pharmacy directors. In addition to examining any systematic differences in coverage of prescription...
opioids compared with nonopioids, we examined the prevalence of utilization management and how this varied across plans and payers, as well as products’ cost sharing. We hypothesized that utilization management strategies such as prior authorization and quantity limits would often be used for nonopioid as well as opioid products and that plans would report relatively little integration of nonpharmacologic and pharmacologic approaches to the management of chronic noncancer pain.

METHODS

We conducted a cross-sectional pilot study from June 16, 2016, through September 14, 2016; the upscaled study was conducted from April 14, 2017, through January 31, 2018. In our pilot study, we evaluated national coverage documents from a large commercial insurance plan, Medicaid program, and pharmacy benefits manager, refining our product selection list, gaining familiarity with the publicly available variables in plan documents, and designing data extraction forms and quality controls. In the current study, we conducted a mixed-methods analysis of coverage policy, whereby quantitative analyses of coverage documents were used to inform key informant interviews, and interviews were used to assist in interpreting results from our quantitative analyses. Our study fulfills the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline and Standards for Reporting Qualitative Research (SRQR) reporting guideline. We obtained informed consent from all informants prior to interviewing them. This study was exempted from a Johns Hopkins Bloomberg School of Public Health institutional review board review, given that no personal or private information was collected from informants. Participants provided verbal consent to use information from the interviews, including direct quotations, without attribution.

Product and Plan Selection

We used an iterative process (Appendix) to select 62 pharmaceutical products of interest commonly used for the treatment of low back pain (eTable 1). We selected 50 plans, which included 15 Medicaid programs, 15 Medicare Advantage plans, and 20 commercial plans of insurers and plan types that cover the majority (72%) of Americans.18,19 We used a representative sampling strategy to simultaneously achieve several goals, including maximizing geographic diversity and assessing states with diverse and differently sized populations (Appendix). We included 16 states that in aggregate represent more than half of the US population, as well as several that have been disproportionately affected by the opioid overdose epidemic, such as Ohio and West Virginia (Figure 1). eTable 2 lists our final selection of plans.

APPENDIX Selection of Products and Plans

Selection of Products

First, we identified six therapeutic classes commonly used for the treatment of low back pain: opioids, non-steroidal anti-inflammatory drugs (NSAIDs), antidepressants, anticonvulsants, skeletal muscle relaxants and topical analgesics. Next, we used the Truven Micromedex RED BOOK (2014) and the FDA’s Approved Drug Products list to populate these classes with specific products of interest. Lastly, we reviewed this list with clinical experts in the treatment of pain and refined it to reflect both conventional practice and clinical guidelines for low back pain, by excluding some products that were either used infrequently or had limited evidence of efficacy in this area.

Selection of Medicaid Plans

We selected 15 states based on varying demographics, such as large and small populations, wealth, level of urbanicity, and those with disproportionately high rates of injuries and deaths from prescription and non-prescription opioids, such as Ohio, West Virginia and Maine.1 Within tertiles of Federal Medical Assistance Percentage (FMAP) scores, we selected 4-6 states with varying population sizes and geographic regions, as defined by the United States Census Bureau. As a result, we selected 1 to 2 states from each of the 9 geographic regions. Using data from the Kaiser Family Foundation,2 we selected Medicaid formularies from the largest Managed Care Organization (MCO) in each state, with the exception of one state’s largest MCO, whose publicly available formulary listed analgesics in a unique fashion. We instead used the formulary from the second largest Medicaid MCO in this state.

Selection of Medicare Advantage Plans

Since their inception, the proportion of Medicare beneficiaries enrolled in Medicare Advantage (“Part C”) has steadily grown, relative to traditional (“fee-for-service”) Medicare.3 In 2017, Medicare Advantage enrollees numbered 19.0 million and accounted for 33% of all Medicare beneficiaries. To maximize...
representativeness, we selected the same 15 states as for the Medicaid plans, with the exception of Vermont, where we substituted Connecticut, due to Medicare enrollment data availability. Connecticut also has a relatively small population and is located in the same geographic region as Vermont. Our overall selection of states for Medicare Advantage also varied greatly in the number of their Medicare Advantage beneficiaries.

We referred to enrollment data from Medicare.gov to select Medicare Advantage Plan Types, such as health maintenance organization (HMO) or preferred provider organization (PPO) plans, with the largest or second largest enrollment in each state. Meanwhile, we ensured selection of plans from the largest 5 Medicare Advantage insurers, including Aetna, Anthem, Humana, Kaiser Foundation and United Healthcare, as well as a variety of smaller payers. We then selected plans with a variety of star ratings, which are offered for reference by medicare.gov. Star ratings are an evaluation of a plan’s overall quality and performance, determined by the Centers for Medicare and Medicaid Services, while taking member experience into consideration.

**Selection of Commercial Plans**

We selected 20 plans derived from a total of 7 states, in order to examine multiple plans within the same state. These 7 states were of different population sizes and geographic regions, selected from the list of states for the Medicaid plans. These states also varied in the magnitude by which they were affected by the opioid epidemic. We examined three commercial plans from each of 6 states, and two commercial plans from the last state.

Recent estimates suggest 74.9 million Americans are covered under private insurance. The majority (57%) of these are covered under what’s considered large group plans (greater than 51 employees). The remaining individuals are covered under either small group plans (19.6%) or the individual markets (23.3%). We focus our analysis on the small and large group markets, given that these markets have been the predominant provider of private health insurance. To identify plans of interest, we used the Kaiser Family Foundation data on individual states and the largest enrollments in both the large and small group health insurance markets. Of note, there is significant overlap of insurance carriers between the individual, small, and large group markets. For example, the top three carriers in California are the same across all three markets with slight differences in ordering. Additionally, within the same insurance carrier, formularies do not vary much outside of cost-sharing levels, such that a UnitedHealthcare formulary in one state will be similar, if not identical, to the UnitedHealthcare formulary in another state. Once a potential insurance plan was identified, we examined the insurance carrier website for access to the specific state-level formulary. Some plans restricted the plan-specific documents and level of information made publicly available; in these cases, we selected a different plan with large enrollment, but in the same state.

**Key Informant Selection**

We conducted 20 key informant interviews with more than 43 informants within many of the identified payers, including 6 interviews representing Medicaid plans, 2 Medicare Advantage or Part D plans, 9 commercial plans, and 3 trade organizations (e.g., Blue Cross/Blue Shield Association of America). We focused on senior executives responsible for the design, implementation, and evaluation of medical and pharmacy policies within the payer, such as chief medical officers, chief pharmacy officers, and vice presidents of clinical operations.

**Health Plan Data Extraction**

We identified publicly available, health plan–specific coverage documents from the internet, including the 2017 plan formulary, summary of benefits and coverage, and evidence of coverage. Three commercial plans examined did not provide a publicly available plan-specific formulary; as such, we extracted data from a national or regional formulary for these plans instead. Each policy document was abstracted by a single reviewer. A second reviewer abstracted 20% of the data, with resulting interrater agreement exceeding 95% and discrepancies resolved by study team consensus. Outcome measures included health plan characteristics.
and chronic pain policies regarding pharmaceutical coverage and utilization management such as prior authorization, quantity limits, and cost sharing. We defined a medication as not covered if it was not listed on a formulary.

**Interview Data Collection**

Individuals were contacted by email and interviewed by telephone using a semistructured script that was developed and iteratively piloted and pretested to maximize the value of the qualitative information received. An interviewer and a research analyst were present for each call, and key comments were transcribed verbatim. The interviews covered 5 key domains: (1) plan responses to the opioid epidemic, (2) coordination between pharmacologic and nonpharmacologic treatments, and the development of (3) innovative strategies, (4) requirements, or (5) technologies to improve the care of patients with chronic noncancer pain.

**Statistical Analysis**

We cleaned the extracted data and used visual inspection to examine data distributions. We then used descriptive statistics to characterize coverage policies and utilization management requirements across insurers and therapeutic classes. To analyze our key informant interviews, we used a grounded theory approach. We organized each interviewee's comments around our 5 broad study domains and identified illustrative quotes to support the
insights derived. Next, we generated a new study document that, for a given domain, listed the diversity of feedback that we received regarding the topic. Finally, we iteratively synthesized this feedback in narrative form.

RESULTS

Of the 62 products examined, 30 were prescription opioids. The remaining 32 were nonopioid analgesics, including 10 nonsteroidal anti-inflammatory drugs (NSAIDs), 10 antidepressants, 6 muscle relaxants, 4 anticonvulsants, and 2 topical analgesics.

Formulary Coverage

The overall proportions of opioids and nonopioids covered by a given payer were generally similar, with commercial plans covering the most products. However, 2 plans covered significantly more opioids than nonopioids; conversely, 7 plans covered significantly more nonopioids than opioids. Table 1 shows coverage of the products we examined across the plans. For example, of the 30 prescription opioids examined, the Medicaid plans covered a median of 19 (interquartile range [IQR], 12-27; median, 63%; IQR, 40%-90%) of these products. A similar proportion was covered by Medicare Advantage plans (median [IQR], 17 [15-22]; 57% [50%-73%]), whereas more than three-fourths of products (median [IQR], 23 [21-25]; 77% [70%-84%]) were covered by the commercial plans. eTable 3A shows the coverage for each examined opioid product across individual plans.

Trends were similar for the nonopioids examined, with a greater proportion of nonopioids covered by commercial plans (median [IQR], 26 [24-27]; 81% [74%-85%]) than Medicaid plans (median [IQR], 22 [21-27]; 69% [66%-83%]) or Medicare Advantage plans (median [IQR], 22 [22-26]; 69% [69%-81%]).

Medicare Advantage and commercial plans had greater coverage for immediate-release opioids (median [IQR], 12 [11-14]; 71% [65%-82%] and 15 [13-16]; 85% [76%-94%], respectively) than extended-release opioids (median [IQR], 4 [3-8]; 31% [23%-62%] and 9 [7-11]; 65% [54%-81%], respectively), whereas Medicaid had approximately the same coverage for both types (median [IQR], immediate-release opioids: 11 [9-16]; 65% [50%-
94%] and extended-release opioids: 9 [4-12]; 69% [31%-88%]). Among all plans, a larger proportion of the examined NSAIDs (median [IQR], 9 [7-10]; 90% [73%-100%]) and antidepressants (median [IQR], 8 [7-9]; 80% [70%-90%]) were covered than anticonvulsants or muscle relaxants.

Our 20 key informant interviews provided insight into the context for the current formulary coverage of pain medications; plans were universally active in modifying coverage for pain treatments to decrease the volume of opioids prescribed (eTable 2). For example, plans have widely begun to implement elements of the 2016 Centers for Disease Control and Prevention guidelines for prescribing opioids for chronic pain, most commonly by limiting opioid prescriptions through the implementation of morphine milligram equivalent limits as well as other quantity or duration limits. Other plans reported having taken, or planning to imminently take, additional measures, some in coordination with other insurers and statewide entities also working to address the epidemic.

### Utilization Management for Opioids

Utilization management strategies were common for opioids, with at least 1 form of utilization management for a median of 15 opioids (IQR, 11-20; median, 91%; IQR, 74%-97%) in Medicaid plans, 15 (IQR, 9-18; median, 100% [IQR, 100%-100%]) in Medicare Advantage plans, and 16 (IQR, 11-20; median, 74% [IQR, 53%-94%]) in commercial plans, generally relying on 30-day quantity limits rather than prior authorization or step therapy (eTable 3A). For example, among Medicaid plans, a median of 11 covered opioids (IQR, 10-15; median, 69%; IQR, 45%-89%) had quantity limits, 8 (IQR, 1-15; median, 42%; IQR, 8%-69%) required prior authorization, and 1 (IQR, 0-7; median, 9%; IQR, 0%-29%) required step therapy. In all cases where quantity limits were observed, the limits provided for the daily use of each product during a 30-, 60-, or 90-day period and failed to distinguish between the first prescription and subsequent prescriptions, as opposed to 7- or 10-day prescribing limits that are increasingly common in state laws and payer policies. All covered opioids within Medicare Advantage plans...

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**Table 3B. Coverage of Opioids Across Medicare Advantage Plans (N=15)**

<table>
<thead>
<tr>
<th>Plan Identification Number (Values in cells represent coverage status and tiers)</th>
<th>1</th>
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<th>13</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine (transdermal)*</td>
<td>NC</td>
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<td>Buprenorphine (sublingual)*</td>
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NC=Not Covered.

*Prescribed for pain.

Oxycodone-naltrexone ER was not offered as an option on medicare.gov to check formulary coverage.

Removal from market during study period.

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had quantity limits but negligible use of either step therapy or prior authorization. Commercial plans also relied on quantity limits for 16 opioids (IQR, 11-20; median, 70%; IQR, 53%-94%), with infrequent use of prior authorization (median [IQR], 4 [1-5]; 15% [4%-28%]) or step therapy (median [IQR], 1 [0-2]; 4% [0%-11%]) for opioids. The restrictiveness of prior authorization requirements varied from plan to plan, with some requiring a medical rationale for the continuation of opioid therapy beyond 2 prescriptions, and others requiring only a diagnosis of chronic pain for authorization of successive prescriptions.

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NC=Not Covered.

<sup>a</sup>Prescribed for pain.

<sup>b</sup>Removed from market during study period.
Utilization Management for Nonopioids

Approximately 1 in 4 nonopioids was restricted through quantity limits across the examined payers, with modestly lower rates in Medicaid plans (median [IQR], 5 [2-8] nonopioids; 24% [10%-38%]) than Medicare Advantage plans (median [IQR], 7 [5-8] nonopioids; 32% [23%-36%]) and commercial plans (median [IQR], 7 [5-8] nonopioids; 28% [20%-35%]). Prior authorization was especially common in Medicaid, with a median of 6 covered nonopioids (IQR, 1-13; median, 38%; IQR, 2%-52%) restricted, as compared with a median of 4 nonopioids (IQR, 3-5; median, 19%; IQR, 10%-23%) in Medicare Advantage plans and a median of 2 (IQR, 0-3; median, 9%; IQR, 0%-11%) in commercial plans. For example, among the 11 Medicaid plans covering celecoxib, which is an NSAID, 7 (64%) had prior authorization requirements, although within-class alternatives like ibuprofen and naproxen were covered without restriction in the same plans. Prior authorization was also common for serotonin and norepinephrine reuptake inhibitor–class antidepressants, among which the prevalence of prior authorization ranged from 31% (duloxetine) to 86% (levomilnacipran) among Medicaid plans. Across all payers, the prevalence of prior authorization varied by drug class, with more restrictions on muscle relaxants (25% of covered products) than antidepressants (17.4%) or NSAIDs (6.7%). As with opioid products, the use of step therapy was uncommon. Utilization management appeared more frequently or at similar rates for opioids than nonopioids across all plans and all utilization management methods, with the exception of prior authorization for Medicare Advantage plans, which was more frequent for nonopioids (median [IQR], 4 [3-5]; 19% [10%-23%]) than opioids (median [IQR], 0 [0-1]; 0% [0%-2%]).

Payers also discussed the use of nonpharmacologic therapies. Many informants identified a need for greater coordination of nonpharmacologic and pharmacologic benefits. Pharmacy policies rarely aligned with corresponding medical policies for pain treatment, in part owing to separation in the design and administration of these 2 types of benefits. Only 1 plan we interviewed had fully integrated nonpharmacological therapies into its step therapy requirements for opioid initiation.

Coverage and Utilization Management for Specific Opioid Products
eTable 3C presents the coverage and use of utilization management for specific opioid products by insurer type. Across all plan types, methadone (49 [98%]) and fentanyl (47 [94%]) were the most common extended-release/long-acting opioids covered for pain. The least frequent extended-release/long-acting opioids covered across all plans were transdermal buprenorphine (19 [38%]) and oxycodone with naloxone (0%).

Of the 15 Medicaid plans we examined, 14 (93%) covered methadone for pain, and among plans covering the product, 7 (50%) used prior authorization, 6 (43%) used quantity limits, and 3 (21%) used step therapy. Medicare Advantage plans most commonly used quantity limits for extended-release/long-acting opioids and never used step therapy for opioids. Commercial plans most often used quantity limits, followed by prior authorization and step therapy.

Product Tiering and Out-of-Pocket Costs
Ten of the 15 Medicaid plans examined required a copayment for covered products, which generally was $0 to $3 and never more than $8 per prescription, and this did not differ between opioids and nonopioids. Cost sharing for the Medicare Advantage and commercial plans examined is shown in eTable 4 in the Supplement. The median (IQR) copayment per 30-day prescription in the Medicare Advantage plans examined was $4 ($2-$10) for tier 1 drugs, $17 ($11-$20) for tier 2 drugs, $47 ($45-$47) for tier 3 drugs, $100 ($95-$100) for tier 4 drugs, and coinsurance of $31 (28%-33%) for tier 5 drugs. Among Medicare Advantage plans, 5 covered opioids (29%) were in tier 2, 6 (53%) were in tier 3, and 3 (20%) were in tier 4. For nonopioids in Medicare Advantage

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**Table 4. Tiering and Out-of-Pocket Costs for Medicare Advantage and Commercial Plans**

<table>
<thead>
<tr>
<th>Tier Placement, Median N (%)</th>
<th>Co-payment in U.S. S (Tiers 1-4) &amp; Coinsurance % (Tier 5), Median (Interquartile Range)</th>
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<tbody>
<tr>
<td></td>
<td>Opioids</td>
</tr>
<tr>
<td>Medicare Advantage (N=15 plans)</td>
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</tr>
<tr>
<td>Tier 1: Preferred Generics</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Tier 2: Generics</td>
<td>5 (29)</td>
</tr>
<tr>
<td>Tier 3: Preferred Branded Drugs</td>
<td>6 (53)</td>
</tr>
<tr>
<td>Tier 4: Non-preferred Drugs</td>
<td>3 (20)</td>
</tr>
<tr>
<td>Tier 5: Specialty Drugs</td>
<td>0 (0)</td>
</tr>
<tr>
<td>All tiers combined</td>
<td>17 (100)</td>
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<tr>
<td>Commercial (N=19 plans)</td>
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<tr>
<td>Tier 1</td>
<td>18 (74)</td>
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<tr>
<td>Tier 2</td>
<td>1 (7)</td>
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<tr>
<td>Tier 3</td>
<td>3 (13)</td>
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<tr>
<td>Tier 4</td>
<td>0 (0)</td>
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<tr>
<td>All tiers combined</td>
<td>23 (100)</td>
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</table>

*Values represent the number of opioids or non-opioids on a given tier in the median plan examined. While Medicare Advantage tiers were consistent across plans, commercial formularies varied in number and definition of tiers.

Commercial analyses based on 8 plans for which copayment data was available.

Analysis based on 4 plans for which homogeneous copayment information was available.
plans, 3 (14%) were in tier 1, 9 (41%) in tier 2, and 3 (15%) in tier 3. Among commercial plans, the median plan placed 18 opioids (74%) and 20 non-opioids (81%) in tier 1. The median copayment per 30-day prescription in tier 1 opioids in the commercial plans was $10 (IQR, $9-$10).

Innovative Strategies

In addition to plan efforts regarding coverage, utilization management, tiering, and costs of opioids and nonopioids, the key informant interviews identified important contextual information regarding decision making as well as emerging innovative strategies to address the opioid epidemic. Plan executives contextualized formulary management within a broader landscape of efforts aimed at reducing opioid prescribing, including analysis of prescribing data to identify high-volume prescribers and patients. To address outlier prescribers, interventions included written warnings, increased training and education, and in rare cases removal from the plan’s network. Some plans deployed academic detailers to the offices of high prescribers to offer one-on-one counseling about opioid risks, treatment alternatives, and buprenorphine prescribing, while others offered online modules and seminars.

Patient-level efforts included case management, pain contracts, restricted recipient programs that lock in high-risk patients to 1 prescriber and 1 pharmacy (lock-in programs), and education about behavioral and mental health resources. Some innovative plans noted prospectively identifying at-risk patients and liaising them with case managers. Others used real-time administrative claims and prescription drug monitoring data to identify and track individuals filling prescription opioids from multiple prescribers and pharmacies. The interviews reinforced the concept that insurers have largely focused on efforts to constrain opioids rather than promote comprehensive strategies to improve treatment of chronic pain or increase access to or better integrate pharmacologic and nonpharmacologic alternatives to opioids.

DISCUSSION

To examine how public and commercial payers have responded to the US opioid crisis, we examined contemporary coverage policies for 62 pharmacologic treatments used for the treatment of low back pain, one of the most common causes of chronic pain for which prescription opioids have been overused. While utilization management strategies were common for opioids, many of the nonopioids examined were also subject to utilization management, especially quantity limits and prior authorization. Step therapy was rarely used. Most opioids were placed on low formulary tiers and associated with copayments of $10 to $15 per prescription. Key informant interviews with plan executives underscored that plans were universally active in modifying coverage policies, although with a primary emphasis on increasing opioid utilization management and focusing on high-risk prescribers and patients rather than promoting comprehensive strategies to improve the treatment of chronic pain or increasing access to or better integrating pharmacologic and nonpharmacologic alternatives to opioids. These findings are important because of how commonly opioids are prescribed, harms that have accrued, and the important role that public and commercial insurers can play in improving the safe use of these products, a role validated by payers in our interviews.

There is a wealth of evidence regarding the association of prescription drug coverage with drug utilization and health outcomes and increasing interest in this as it applies specifically to the coverage of prescription opioids and other treatments for chronic noncancer pain.

Because of the limited evidence that long-term opioid use improves pain, function, and quality of life, nonpharmacologic therapy and nonopioid analgesics are preferred as first-line treatment for chronic pain; coverage policies should reflect this and quality improvement efforts should incentivize this.

Requiring patients and health care professionals to navigate burdensome and diverse utilization management policies for opioid alternatives likely results in slower adoption and implementation of these treatments. By contrast, coordination of pharmacologic and nonpharmacologic treatment options, such as through step therapy requirements for opioids, could incentivize the use of treatments with better evidence and with less addictive potential. Our observation that only 1 plan fully integrated nonpharmacologic therapies into its step therapy requirements for opioid initiation underscores the lack of a comprehensive, evidence-based approach to the specific act of opioid prescribing, as well as the broader issue of treating chronic pain.

The lack of alignment of pharmacy and medical policies within individual payers also reinforces the disconnect in linking patients to the right care at the right time in the course of their disease. While physician overprescribing of opioids may have fueled the opioid epidemic, inconsistencies between payer policies and evidence-based practices for opioid prescribing pose significant barriers to ensuring that patients with chronic pain receive high-quality, multimodal, evidence-based treatment.

The quantity limits used by the plans we examined were largely based on a 30-day supply or longer, with no difference based on dose or initial vs subsequent prescription. These types of limits may have limited utility for reducing nonmedical use, given recent research showing that the probability of long-term opioid use increases sharply among patients receiving just 5 or more days of opioid therapy at the time of initial prescription.

Recent legislation in a number of states have set 7-day or shorter limits on initial opioid prescriptions, and CVS/Caremark, one of the nation’s largest pharmacy benefit managers, announced in September 2017 their intention to institute similar limits on initial prescriptions. Although more studies are needed to understand the intended and unintended impact of these types of policies, quantity limits represent one of many policies that insurers should consider.

Limitations

Our study had limitations. First, publicly available documents were not consistently available for all payers, and we have no information on the reliability of the documents we obtained. However, these documents are used by many parties, are regularly updated, and serve as a principal method of communication regarding coverage policies. Second, our analysis focused on a
sample of 50 plans and does not include some health systems and payers such as the Veterans Health Administration and workers’ compensation plans. Third, the opioid epidemic is a dynamic and evolving public health crisis and our work suggests that payers continue to modify their policies to respond to a changing marketplace as well as public and population health priorities. This fact underscores the importance of ongoing evaluation of coverage policies over time, including their impact on utilization, processes, and outcomes of care. Fourth, as with all qualitative work, ours may have been subject to our own biases and preconceptions, although we used several approaches to minimize the degree to which this may have influenced our results. We did not explore the rationale behind the implementation of different utilization management tools, such as prescribing limits vs prior authorization. Fifth, we limited our analysis to pharmacologic treatments, yet nonpharmacologic therapies, ranging from physical therapy to acupuncture to counseling, represent important modalities in chronic pain management. Plan coverage, availability, and variation in nonpharmacologic therapies for pain management are not well understood and warrant further study.

CONCLUSIONS

The opioid epidemic is a complex crisis that requires partnership across multiple sectors to respond with effective clinical and public health strategies. To our knowledge, our analysis is the largest and most comprehensive examination of recent coverage policies among a diverse sample of Medicaid, Medicare Advantage, and commercial insurers in the United States. Our findings point to opportunities among insurers and pharmacy benefit managers to recalibrate the role of opioids in pain care, expand access to opioid alternatives through coverage and reimbursement policies, and measure the impact of such changes on patient outcomes. Furthermore, such efforts must be implemented in the context of a comprehensive suite of interventions that targets drivers of the epidemic.

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REFERENCES


APPENDIX AND eREFERENCES


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The JMCN publishes topics on managed care and related subjects, like quality & utilization management, patient advocacy, current trends, changing legislature, leadership tips and more.

For more information on submitting an article, contact April Snyder at asnyder@aamcn.org or view the author guidelines at www.aamcn.org/jmcn.html
Older People and Their Families’ Perceptions About Their Experiences with Interprofessional Teams

Sherry Dahlke, PhD, Kim Steil, Rosalie Freund-Heritage, MSOT, Marnie Colborne, Susan Labonte, MSN, and Adrian Wagg, MBBS

Summary

In this article, we examine older people and their families’ perceptions about their experiences with interprofessional teams. Naturalistic inquiry was used in combination with qualitative descriptive methods to provide a comprehensive summary of older people and their families’ experiences with interprofessional teams. Interviews were conducted with 22 people from 11 families. The families had experiences with teams in a variety of settings, such as community, residential care and hospital.

Key Points

- Older people and their families wanted communication about what was going on, regardless of whether the news was good, bad or unknown. They also wanted care that took the concerns of the older person into consideration.
- Communication was a necessary ingredient to ensuring that the older person’s unique concerns were known to the interprofessional team. These perceptions were discussed in the themes of communication and patient-centred care.

INTRODUCTION

The health care of older persons is often complex due to an increased incidence of long-term illnesses, atypical presentations of acute illness and changing social circumstances.1,10,15 This complexity increases the likelihood of multiple professional disciplines becoming involved in the management of older people’s health.41,45 When multiple disciplines are involved they often work in teams known by a variety of names, such as multidisciplinary, interdisciplinary, transdisciplinary and interprofessional; in this study, we use the term interprofessional team, defined as two or more professional disciplines in communication with one another about older people’s health.12 Researchers have reported some successes in improving the care of older people when interprofessional teams are involved.1,2,4,45 However, the processes teams use to incorporate the views of older people and their families in their decision-making, is unclear. Older people may be more dependent on caregivers, such as friends or family, and the more people involved the more the potential for miscommunication. To better understand how to avoid miscommunication, it is important to understand older people and their families’ perspectives on their experiences with interprofessional teams (Figure 1).

BACKGROUND

Interprofessional teams are frequently promoted as a means to provide quality, safety and efficiency of care within health care.6,35,43 As well as interprofessional team involvement, actively involving older people in their own care has been associated with improved health and more effective healthcare utilization.3,16 However, older people face obstacles to active engagement in their care, such as low health literacy42 or delirium.17 Moreover, there is an increased incidence of dementia with advancing age which can compromise individuals’ ability to interact effectively with multiple professionals.44 In cases of dementia, delirium or both, the families or informal caregivers of older people are frequently involved in decision-making on their behalf.23 In this situation, family involvement adds to the complexity of care and must be considered by interprofessional teams working in this area.

Scholars who have examined the characteristics of effective interprofessional teamwork suggest that to be effective, team members must have social competence, a willingness to share information, to be able to negotiate and solve problems.28 Manser’s (2009) review of the literature about patient safety and teamwork indicated that teams require patterns of communication, coordination and leadership to support their effectiveness. Yet, there is evidence that power issues, confusion about roles, inconsistent use of language and inadequate organizational supports are common challenges for interprofessional teams.2,11,12 These challenges reflect social, political and economic complexities associated with interprofessional collaboration.9,12 Scholars have developed an interprofessional framework identifying
To reduce duplication, clinical errors and enhance the quality of care, although effective interprofessional collaboration is believed to shroud in a lack of understanding about the processes (the how) by which professionals collaborate and communicate. In other words, despite three decades of literature examining the efficacy of interprofessional teams, there remains an absence of evidence to guide teams in patterns of communication that will support collaboration with older people and their families.

There is also little research examining how interprofessional teams work with older people and their families. In a recent study, a scoping review which examined the factors associated with interprofessional teams’ success when working with cognitively impaired older people, only 3 of 34 papers reviewed reported any information- how-be-it- scant- about how team members worked with older persons or their families. This suggests that either researchers did not report this information, or that teams did not actively engage with this population. We found only four other studies that examined older people’s experiences with interprofessional teams. Berglund et al. (2013) suggested that older people were satisfied with their care because they got attention and their needs were met when the interprofessional team was involved. Older people who participated in this study were cognitively intact and thus more able to advocate for themselves and to interact with interprofessional teams than would those with cognitive impairment. Lamb and colleagues reported that cancer care recipients (not all were older people) wanted to make decisions about their care with the help of families and healthcare professionals. The perspectives of older people and in particular those who may be less able to communicate their desires and needs were missing from this study. Eloranta et al. (2008) suggested that interprofessional collaboration could improve the care of community dwelling older people. However, older people in this study did not recognize that collaboration was occurring, leaving questions about what type of interaction older people wanted and would find helpful. In a workshop with older people aimed at improving their engagement with interprofessional teams, older people reported improved self-efficacy but did not increase their engagement, leaving questions about what type of communication older people want.

Taken together, little is known about how (the processes) interprofessional teams communicate and work with older people and their families. Moreover, little is known about older people and their families’ perspectives on their experiences with interprofessional teams. Learning how older people and their families’ view these interactions is a first step in understanding what they want from interprofessional teams. Therefore, the aim of this exploratory study was to gain an understanding of these perspectives about experiences with interprofessional healthcare teams.

**METHODS**

**Design**

This was a naturalistic inquiry using qualitative descriptive methods to provide a comprehensive summary of older people and their families’ perspectives on their experiences with interprofessional teams. Data were collected from June to December 2015 and included individual, dyad and triad interviews.

**Sampling**

We used purposeful sampling to include older people and/or his or her family who had experiences with an interprofessional team. The clinicians from three interprofessional teams (an acute care team, a community team and a rehabilitation team) provided older people and their families with an information letter about the study that included the purpose of the study, information on potential risks, and the researchers’ contact information. Older people and/or family members who were interested in participating contacted the researcher or consented to have the clinician share their contact information with the researcher.

Whenever possible we interviewed the older person and their family member together. Unfortunately, this was not always possible either due to family members availability, or because the older person with dementia was unable to remember or describe their experiences.

**Ethical Considerations**

Research Ethics Committee approval was obtained from the University of record and operational approval from the participating health authority. All families were informed about the study, the voluntary nature of participation and confidentiality. All signed consent forms prior to their participation. Consent was obtained from older people when family and healthcare professionals agreed that they could provide informed consent. When the older person was unable to provide informed consent, their family provided consent and the older person received a simple explanation of the study and was asked for their assent prior to data collection.
Data Collection

Interviews occurred at a place of participants’ choosing. Most of the interviews were conducted in participants’ homes. Two were conducted in a quiet corner of a coffee shop at a hospital. The first author conducted all of the interviews using a semi-structured interview guide after obtaining informed consent. Questions were open-ended, focusing on exploring participants’ experiences and perspectives. Questions included but were not limited to: “tell me about your (or your family member’s) experiences being cared for by a variety of healthcare professionals”; “How were your perspectives considered by the professionals?”; “How were your family’s perspectives included?”; and “How would you like to engage with interprofessional teams?” The last question was included due to Eloranta et al. (2008) finding that despite professionals belief that they were collaborating with older people, the older people did not recognize the engagement as collaboration, leaving questions about what type of engagement older people want with interprofessional teams.

Data Analysis

Data were audio-recorded and then transcribed verbatim; all identifiers were removed prior to data analysis. When interviews provided no new perspectives, data were considered saturated. Inductive content analysis was used to analyse the data. Analysis began with two of the researchers (S.D. & M.C) reading the transcripts carefully line-by-line, highlighting text that described older people and their families’ perspectives. Key words or codes were entered into NiVivo as preliminary codes. Next, the first author and two others (M.C. & S.L.) independently analysed the data using line-by-line coding and compared their codes to the NiVivo codes. After discussion on the codes, S.D., M.C. and S.L. reached an agreement about codes that represented the data. They then grouped similar codes together to form categories. The categories were then examined for similarities and differences to develop meaningful themes, using quotes from participants to support themes and categories. Discussion on analysis of the data also included comparing and contrasting older people and their families’ experiences. The first author then wrote a draft of the findings based on the analysis and discussions that had occurred among S.D., M.C. and S.L. Finally, an iterative analytic process among all authors occurred in which categories and themes were interrogated for whether or not they were a realistic representation of the data. This process served to further develop the themes as a description of older people and their families’ perspectives about engaging with interprofessional teams.

Validiity and Reliability

Analytical rigour was assured through incorporating general considerations for qualitative research. The trustworthiness of this study was enhanced by attending to the characteristics described by Grove, Gray, and Burns (2015). The credibility of the findings was enriched by triangulation of the data among the researchers. Moreover, that data for each of the themes presented both positive and negative examples to demonstrate the range of older people and their families’ experiences also enhances credibility. The attention to describing the contexts and the rich description provided by participants’ quotes supported the categories and themes and enhanced the transferability of these findings. A transparent analytical decision trail, as described in the analysis section, and the rigorous discussions among the co-authors contribute to the dependability of the findings. Discussing preliminary codes, use of NiVivo and the rigorous conversations among the co-authors about whether the categories and themes were a realistic representation of the data contributed to the dependability and confirmability of the findings.

FINDINGS

Eleven families (22 individuals) participated in this study. Table 1 contains information about the family groupings and their ages. Four group and nine individual interviews were conducted. Older people and their spouses ranged in age from 65 to 89 years and adult children ranged in age from 47 to 66 years. Experiences with interprofessional teams were described from an older person’s perspective (one), a family perspective that included the older person (three) and a family perspective in which the older person’s perspective (one), a family perspective that included the older person (three) and a family perspective in which the older person’s perspective was not included due to advanced dementia (seven). Several families talked about their experiences with interprofessional teams in more than one setting; these settings included community, acute care, rehabilitation and nursing homes. Older people and their families agreed that families should be included in communication and healthcare decision-making. This is due to the belief “that [families] really know best the parent’s needs, or the safest and their best interest” (Carol, daughter). Older people and their families wanted communication about what was going on, regardless of whether the news was good, bad or unknown. They also wanted care that took the unique concerns of the older person into consideration. Communication was a necessary ingredient to ensuring that the older person’s concerns

<table>
<thead>
<tr>
<th>Number</th>
<th>Family members</th>
<th>Ages</th>
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<tbody>
<tr>
<td>1</td>
<td>Mable (daughter)</td>
<td>55</td>
</tr>
<tr>
<td>2</td>
<td>Lucy (wife)</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Zack</td>
<td>86</td>
</tr>
<tr>
<td>3</td>
<td>Louise (wife)</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Bob</td>
<td>79</td>
</tr>
<tr>
<td>4</td>
<td>Martha (son)</td>
<td>89</td>
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<tr>
<td></td>
<td>Ray (son)</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Carol (daughter)</td>
<td>61</td>
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<tr>
<td></td>
<td>Pam (daughter)</td>
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<td>5</td>
<td>Alice (daughter)</td>
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<tr>
<td>6</td>
<td>Grace (wife)</td>
<td>80</td>
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<td></td>
<td>Ed</td>
<td>83</td>
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<tr>
<td>7</td>
<td>Irwin (wife)</td>
<td>79</td>
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<td></td>
<td>Gladys (wife)</td>
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<tr>
<td></td>
<td>Brent (son)</td>
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<tr>
<td>8</td>
<td>Marliss (daughter)</td>
<td>57</td>
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<tr>
<td></td>
<td>Jenny</td>
<td>79</td>
</tr>
<tr>
<td>9</td>
<td>Deloris (daughter)</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Earl (husband)</td>
<td>85</td>
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<tr>
<td>10</td>
<td>Sandy (daughter)</td>
<td>52</td>
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<td></td>
<td>Albert</td>
<td>85</td>
</tr>
<tr>
<td>11</td>
<td>Alice</td>
<td>78</td>
</tr>
</tbody>
</table>
were known to the interprofessional team. These perspectives are discussed further in the themes of communication and patient-centred care.

**Communication**

Older people and their families identified effective communication both within the team and to them as necessary ingredients in ensuring that the older person received care that took their needs into consideration. Older people and their families felt confident that care would meet the older person’s needs when professionals listened and answered questions, and explained what was happening.

**Listened and Answered Questions**

An important element of good communication was active listening to older people and their families’ concerns. Active listening required professionals to engage in conversation with the older person and their family until it was crystal clear that both the professional and the older person/family understood the message[s] being conveyed. When asked what professionals should do, one older person explained: “listen to them. And make sure they understand you” (Alice, older person). When it worked well, explanations were worded in ways that made it easy for older people and their families to understand. One older person remarked: “I could ask them questions and understood what they were saying” (Alice, older person). Another husband explained: “They keep you well informed. You stop asking questions only when you run out of questions” (Earl, husband). This husband explained that he was impressed by the interprofessional team’s willingness to answer his and his children’s, questions about their mother.

Listening and answering the questions of families as well as the older person was important because if the family understood what was happening they would be able to share the older person’s values when the older person was unable to do so. This allowed families to contribute to the plan of care. One older person explained how having family understand the plan of care was reassuring because “the family can explain to [the older person] what they’re trying to do” (Martha, older person). Family members who understood the plan of care and were trusted by the older person were able to help explain the care plan in a way that could be more easily understood by the care recipient.

**Explain What Was Happening**

Older people and their families wanted information about what was going on and the plan of care. When professionals took the time to explain what was happening, families felt recognition of the family unit and felt confident that their family members’ needs were being considered. As one daughter relayed: “they explained how the whole process would probably play out. I didn’t worry about her at all. I really felt like they cared about me too” (Mabel, daughter). As this daughter explained open communication contributed to confidence that the team was interested in their older family member’s needs.

Some of the teams identified a specific member from the interprofessional team that families could go to for questions about how the older person was progressing. This person could then help to direct them to the professional who could answer specific questions. As one daughter explained: “The social worker is the contact person that we can talk to. The physio, the occupational therapist, they keep in contact with us too. The nurses give you information; it is really well done” (Sandy, daughter). Having one person to contact provided direction in the sometimes confusing healthcare environment. Moreover, when the interprofessional team made it a practice to explain what was going on, older people and their families were reassured by the culture of open communication.

Just as family were reassured when they received communication about the older person, if communication was ineffective among the interprofessional team members or between the healthcare providers and the older person/family, the result was family/patient anxiety and eventually suboptimal care. As an example—Bob had dementia and was not able to provide answers to many of the healthcare providers’ questions. As a result, his wife Louise stayed close to his side. She explains their experience:

> “There was a total breakdown [of] communication, everything fell apart. They totally lost track of what was going on, why he was there, his history. He didn’t know who his nurse was with dementia, you’ve got to introduce yourself more than once and that didn’t happen. His food would sit there and nobody would help him. I felt like there wasn’t a team. Now I know there was, because people were coming and going all the time but I don’t know who they were. I don’t know what their purpose was [or] what they were trying to accomplish with him. People would just come in and they’d start doing things and talking to him. I was invisible. And I had to interject. I am his wife”

>(Louise, wife)

Her observations at her husband’s bedside lead her to believe that the healthcare providers were not talking to one another and therefore, she had to stay as close to him as possible to make sure he would receive appropriate care. The communication gaps resulted in care that did not appear to be focused on Bob’s needs, which included dementia, a broken arm and broken hip—the reason he was in the hospital. These gaps in communication also contributed to Louise’s belief that she had to be a strong advocate for her husband.

**Person-Centred Care**

Older people and their families wanted the healthcare providers to provide care that recognized the older person as unique. Family members perceived open communication with the older person, them and among team members as evidence that the professionals were “looking at the whole person” (Sandy, daughter) and this decreased their anxiety about whether or not their family member’s needs would be addressed. If the older person was receiving care that centred on his or her needs, then family did not need to advocate for the older family member. When communication was evident among the team members and with the older person and the family, the care was perceived as consistency. When communication was perceived as lacking or absent, then older people felt devalued and their family members
perceived a strong need to advocate for their older family member.

**Consistency**

Family members viewed professionals talking among one another as evidence that they were concerned about providing uniform care that took the unique needs of the older person into consideration. They recognized that it took a team to provide around the clock care for their family member and to do that effectively professionals would need to communicate with one another. When interprofessional team members were talking to one another, it was viewed as evidence that “everybody wanted to make sure they were looking after him properly, and it was a wonderful example of teamwork” (Louise, wife). Another daughter identified that interprofessional communication fostered consistency in the care her father received. “Consistency. I think the team actually works as a team” (Sandy, daughter). Consistency was only possible if the members of the team were talking and listening to one another as well as to the family. If care was perceived as consistent, or if something happened and it was explained, then families were less anxious and were less likely to feel the need to strongly advocate for their older family member. The consistent communication among the interprofessional team was seen as evidence that there was a unit culture of concern for older patients.

Unfortunately, not all of the participants’ experiences were of a culture that exhibited concern for the older person. One family described their experience in which they perceived that their older family member’s needs were not considered nor was there communication to them about what was going on with him. Rather, his needs were inconsistently met. One night they got a call from the nursing home where their older family member resided explaining that he had fallen. They spent time in the emergency department with him, yet were never told by professionals at either the nursing home, or the emergency department about what had happened, or the implications of the fall to his health. “I don’t know exactly the whole situation. He fell on his face and broke his nose and cut his forehead open.” (Grace, wife). The next day the family attended a meeting with the interprofessional team to discuss his care, a meeting that had been scheduled long before the fall. The fall was not mentioned, nor was his recent weight loss, diabetes and dementia. Rather the conversation focused on the financial implications to the nursing home in providing one-to-one care to monitor his wandering. The lack of discussion on his care needs increased the family’s anxiety about their family member if their older family member received care that did not meet his or her needs and the reasons for this were not communicated to them. Thus, the findings of this study provide valuable insights into the perspectives of older people and their families, about their communication and care needs.

Devaluing of Older People

Many of the family members shared their belief that there was a devaluing of older people within healthcare institutions. This belief was linked to experiences in which their older family member’s needs were not communicated among the healthcare team and/or they perceived that the older person did not have their needs met. This inadequate communication was viewed as a reflection of the healthcare system not supporting care of older people. “Don’t spend money on a senior, because they’re on their way out. Spend money on someone younger. They are more valuable to society” (Ray, son). Families believed that fiscal restraints caused time pressures, which contributed to rushed or diminished communication with older people and their families. This resulted in, older people feeling like “you’re not a person. You’re a task” (Brent, son). Another wife echoed these sentiments when she suggested that lack of communication contributed to “patients not feeling that they are cared about. They feel like a burden and the families, they feel like they are in the way” (Louise, wife). When healthcare providers failed to communicate about his needs, which necessitated him to be mobilized in an unusual manner, the older person’s perception was: “they didn’t give a damn about you” (Bob, older person). It would seem that lack of communication was viewed as a lack of concern for the older person.

Families identified that they did expect that sometimes care or communication would be less than perfect. However, if care provided did not take the care needs of the older person into consideration and healthcare providers communicated what had gone wrong, then the family felt reassured that healthcare providers did consider the needs of their older family member overall. Families’ belief that they needed to assume strong advocacy for their older family member to ensure that their needs were considered hinged on whether or not healthcare providers communicated openly when unexpected things happened or if something went wrong.

**DISCUSSION**

To our knowledge, this is the first study providing evidence about older people and families perspectives about engaging with interprofessional teams. Findings from this study illuminate and provide depth of knowledge about how older people and their families’ perceived the importance of communication about what was happening in the care of the older person, regardless of the nature of the news. Central to older people and families’ concerns was the need to take into consideration the older person’s unique needs in care planning. Communication with older people, their family and with the healthcare team was viewed as crucial in order to provide care that considered the older person’s needs. Family members felt the need to strongly advocate for their older family member if their older family member received care that did not meet his or her needs and the reasons for this were not communicated to them. Thus, the findings of this study provide valuable insights into the perspectives of older people and their families, about their communication and care needs.

This study contributes to an emerging body of literature examining family caregiving for older people. 13,19,22 Similar to the families in this study, others have identified that families consider it part of their responsibility to be involved in supporting family members as they age. 13,31 Jacelon’s (2006) study identified that families were a moderating factor in the hospitalization of older people by acting as an advisor, making decisions when the older patients were unable to do so and supporting (often emotionally) older patients through their visits. Although these studies reported on family involvement in older adults’ healthcare concerns, there was little mention of how interprofessional teams either facilitated or deterred family involvement. This study sheds light on how professionals’ communication about the older person’s unique needs with the older person and their family is a significant factor in whether or not families believe they need to take a strong
advocate role on behalf of their family member.

Much of the literature about interprofessional collaboration focuses on issues among professionals, rather than how care recipients (not necessarily older people) and their families’ perspectives are incorporated. One exception is a study that examined families’ involvement in intensive care units, which identified that family members provided continuity when communication among interprofessional team members was inadequate. Similarly, in this study, families felt it was necessary to step in and advocate for their family member, when they were unable to advocate for themselves and when interprofessional team communication was fractured. Communication and team cohesion can support older people and families’ experiences with interprofessional teams. Our findings suggest that families who witness and experience interprofessional communication perceive a culture of concern for their older family member. Scholars have illustrated that communication occurs through behaviors, feelings and thoughts about what is occurring. Thus, being ill or having an ill family member can affect how older people and their families communicate, just as a chaotic work environment can influence how healthcare professionals communicate. In this study, having dementia affected many of the older people’s ability to communicate with healthcare professionals, leading to more reliance on their families.

Older people and their families in this study also valued healthcare professionals’ care strategies that took the perspectives of the older person into consideration—often articulated as person-centred care. Morgan and Yoder’s (2012) concept analysis of person-centred care identified a long history of the use of this concept within health care, despite a lack of consensus on its meaning. They suggested common attributes of person-centred care as holistic, individualized, respectful and empowering. McCormack (2003) identified that respect for values in providing person-centred care is holistic, individualized, respectful and empowering. Mc coy et al.’s (2010) framework identified contextual issues such as the organizational or unit culture as affecting interprofessional team collaboration. Older people and their families in this study described team culture as either positive or negative depending on their experiences with that team. Positive experiences were reported when families were included as part of the older person’s team through open communication and when the older person’s needs were recognized. Since this study did not include the interprofessional teams’ perspectives we do not know how institutional support may have contributed to the teams’ ability to include family members. More research aimed at understanding how these issues could contribute to concrete strategies for improving interprofessional communication with older people and their families is required.

IMPLICATIONS

The findings from this study suggest that if interprofessional teams communicate regularly with older people and their families about care, they are more likely to incorporate older peoples’ needs, particularly in the context of cognitive impairment. While the importance of communication seems obvious, this study highlights the pivotal role communication has in how families interpret their need to be a strong advocate for older people and how families view the teams’ interest in meeting their family members’ needs. Nurses have a pivotal role in facilitating communication between various professionals and older people and their families. Moreover, listening to older people and their families about the older person’s unique needs and passing this information to the interprofessional team is a key role for nursing. Most importantly, understanding that older people and their families just what to understand what is going on even if it is unknown could encourage nurses and other professionals in communicating regularly. More research into understanding how to enhance effective communication with older people and their families is warranted. Such research could provide guidance to healthcare leaders in planning for the time and infrastructure needed to promote interprofessional collaboration with older adults and their families.

LIMITATIONS

This study is limited in size, scope and context. Although we endeavoured to sample broadly, all but one of the older participants experienced some type of dementia. The existence of dementia limited older peoples’ ability to reflect on their experiences and, as a result, family members strongly influenced the findings. Moreover, most of the participants described their experiences as either good or bad, rather than somewhere in between. There may, therefore, have been bias in recruitment, families with either strongly positive or negative experiences being more likely to participate. Further research that includes larger number of families, a variety of cultures and in different contexts, such as rural and urban settings, could add to an understanding about how interprofessional teams could best interact with older people and their families.

CONCLUSIONS

This study’s examination of older people and their families’ perspectives of interprofessional teams revealed that families are a necessary and integral part of the care of older people, particularly in the context of impaired cognition. Older people and their families wanted interprofessional teams to recognize their important role as advocates, communicate openly and provide person-centered care. More research is needed to understand the interprofessional teams’ processes in order to better support collaboration with older people and their families.

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REFERENCES


The Extent of the Opioid Crisis—Financial Impact on the US Health Care Delivery

Alice Barros, BSN, RN and Jamesetta Halley-Boyce, PhD, RN, FACHE

Summary

Opioids are highly addictive drugs that place patients at risk for abuse, misuse, dependence, and death. Over the last 20 years, there has been a dramatic rise in opioid-related deaths in the United States. This paper explores ten observational studies that discuss the clinical, economic, and social impact of the opioid crisis in the United States. The purpose of this literature review was to better understand the recent findings on the opioid crisis and explore the extent of the issue.

Key Points

- Databases including CINAHL, MEDLINE, Academic Search Complete, and SPORTDiscus were used. It can be summarized that the opioid crisis has significantly impacted our healthcare delivery through increased emergency visits, in-patient admissions, outpatient services, and mortalities.
- There is a need for further research in this topic especially in differentiating between prescription drugs and illicit drugs. However, the financial impact of the opioid epidemic is astronomical.

INTRODUCTION

The misuse and addiction to opioids is a major public health concern. Opioids are drugs that include prescription pain relievers such as oxycodone, hydrocodone, and morphine, as well as illicit drugs such as heroin, and synthetic opioids such as fentanyl. In 2015, 2.5 million people in the United States had an opioid use disorder and 90 people died every day from an opioid overdose. Of those 2.5 million Americans, 77% used prescription drugs, while 23% used illicit drugs. Individuals who become dependent on these prescription pills may transition to heroin, as it is a cheaper alternative that results in the same high without the need of a doctor’s prescription. Narcan, the opiate antidote, is used more frequently at increasing dosages, putting the future availability and cost of the drug at high risk.

The opioid crisis has a huge financial impact in our healthcare delivery system. It has caused dramatic increases in emergency room visits, hospital inpatient admissions, and outpatient services. The total spending for the opioid crisis in 2013, was approximately $78.5 billion—accounting for healthcare and societal related costs. The purpose of this literature review is to more clearly define the opioid crisis and the extent of the clinical, economic, and social burdens in the United States that emanate from it. The focus of this review is to analyze the recent data on this important issue. Everyone has a role in ending this crisis and there is a need to better recognize and address the magnitude of this issue.

LITERATURE SEARCH

The CINAHL, MEDLINE, Academic Search Complete, and SPORTDiscus databases were searched using combinations of the following keywords: “opioid,” “opiates,” “opioid overdose,” “opioid abuse,” “opioid misuse,” “opioid crisis,” “cost,” “finance,” “healthcare utilization,” and “economic burden.” Articles that included these keyword terms in either the title of the article or the abstract were included. Articles that did not discuss financial aspects of the opioid crisis were excluded. The search was limited to the English language with articles that were published between 2013-2018, to ensure a current perspective on the topic. In the process of selection, the articles abstracts were first screened to determine relevance of the topic, and then the full text was analyzed to determine eligibility. Ten articles were selected as they met the search criteria. These articles were thoroughly synthesized and critically appraised. One individual, a registered nurse, participated in the literature review and analysis.

SYNTHESIS ACROSS STUDIES

All ten studies in this systematic review discussed the economic and clinical burdens of the opioid crisis. Two articles discussed the social implications to the issue as well. Eight of the articles were retrospective cohort studies, while two of them were case control studies. All of the articles are observational studies and are considered to be in the middle of the hierarchy of evidence.
pyramid, just below randomized control trials. These studies have good methodological quality, adding overall strength to the study’s findings.

Four studies compared opioid abusers versus a control group of non-opioid abusers.\textsuperscript{2,5,10,12} Two studies discussed both heroin and prescription opioid abuse and differentiated their findings.\textsuperscript{8,9} Four studies specifically chose to exclude heroin related cases in their studies as they wanted to focus on prescription opioids only.\textsuperscript{2,5,12,15}

All of the studies used the ICD-9-CM diagnosis code to identify opioid abuse/misuse/dependence. However, it was found that three studies were unable to completely distinguish between prescription opioid related cases and non-prescription through the ICD-9-CM diagnosis code.\textsuperscript{5,7,13}

Similarly, five studies identified that it is possible that diagnoses could have been miscoded.\textsuperscript{2,5,10,12,15} These are limitations that can add bias to the study results. Coding needs to be specific and accurate as medical billing is associated with those codes.

Moreover, insurance status was discussed in four studies.\textsuperscript{5,7,8,13} Two studies included only commercially insured patients as they excluded patients 65 years and older.\textsuperscript{10,15} Two studies included commercially insured and Medicare patients.\textsuperscript{12,16} These studies that discussed primary payers allowed for a better understanding of healthcare disparities and the socioeconomic issues of the opioid crisis.

**ANALYSIS**

**Clinical Implications**

The misuse of opioids can lead patients to risks such as abuse, addiction, overdose, and death. National statistics for opioid related deaths were discussed in six articles to emphasize the magnitude of the issue.\textsuperscript{5,7,8,9,13,16} Specifically, Hsu et al. (2017), explored heroin and prescription-opioid related in-patient mortalities between 2001-2012; results indicated that in-patient mortality rates for heroin were unchanged over time and there was a slight decrease in prescription related deaths. These findings are important to understand as researchers need to follow mortality trends to understand the severity of the health threat and whether the numbers are improving.

Co-morbidities were studied in eight studies.\textsuperscript{2,5,8,10,12,13,15,16} Five studies included co-morbidities associated with opioid abuse such as psychiatric disorders, substance abuse, organ system disorders, and infections; these comorbidities were analyzed through a regression model to ensure correct charges and codes.\textsuperscript{2,5,10,12,15} Baser et al. (2014), in particular, found that more than 50% of the patients with diagnosed opioid abuse had comorbidities of psychiatric problems, other substance abuse, arthritis, and/or low back pain. Similarly, Pasquale et al. (2014) found that patients with diagnosed opioid abuse have higher pain and psychiatric comorbidities when compared to non-abuse control patients. Moreover, Shei et al. (2015) found that opioid abuse might exacerbate existing comorbidities. A study by Hsu et al. (2017) analyzed the number of chronic co-morbidities through a software and found that between 2001-2012, the mean number of comorbidities increased in heroin and prescription opioid patients. Ronan & Herzig (2016), focused on serious infection rates due to intravenous drug abuse as a morbidity. Results indicated that between years 2002-2012, the number of hospitalizations related to an infection such as endocarditis, osteomyelitis, septic arthritis, or epidural abscess, dramatically increased.\textsuperscript{13} It is important to understand the association between medical and psychiatric co-morbidities with opioid dependence, as it can directly affect patient stabilization, treatment, and adherence to treatment plan.

**Economic Implications**

Healthcare resource utilization in opioid abusers was explored in nine studies.\textsuperscript{2,5,8,9,10,12,13,15,16} It was determined that opioid abusers utilized more health services such as emergency room visits, inpatient admissions, outpatient services, and rehabilitation, causing total healthcare costs to rise dramatically. Baser et al. (2014), found that in the veteran population, diagnosed opioid abusers used inpatient services more often (34.45%) when compared to non-opioid abusers (18.01%), as well as emergency room visits (34.69% vs. 20.14%). Inocencio et al. (2013) found that about 33% of all emergency room opioid related cases became inpatient admissions. Moreover, Hsu et al. (2017) found that heroin related admissions increased 0.11 per 100,000 patients annually, and prescription opioid related admissions increased 1.25 per 100,000 patients annually, over the period of 2001-2012. The study by Shei et al. (2015) found that high cost patients, or patients that are in the top 20% of total healthcare costs, with opioid abuse had longer length of stays (16.1 days vs 2.9 days) when compared to lower cost patients. Furthermore, Chandwani et al. (2013) found that the estimated cost of an emergency/inpatient hospital visit was $18,891 and the total healthcare related costs for 2008 was $9.5 billion.

Mortality costs in particular, accounted for $17.9 billion in 2009 with heroin reaching over $4 billion and prescription opioids over $13 billion.\textsuperscript{8} Similarly, Florence et al. (2016) found that mortality cases cost more than $21.5 billion in 2013. To minimize deaths associated with opioid abuse, access to these drugs must be controlled.

All ten studies explored the costs associated with the opioid crisis as the focus of this review was to understand the financial consequences of this issue. According to Inocencio et al. (2013), the total cost for the opioid epidemic in 2009 was $20.4 billion, accounting for direct costs such as emergency department visits, inpatient visits, ambulances, Naloxone, as well as indirect costs such as absenteeism costs and mortality. Florence et al. (2016), found that in 2013, the total costs including medical care, treatment, and criminal justice costs were $78.5 billion. These numbers are alarming and suggest that the total costs are dramatically increasing over the years.

Total costs were further broken down into healthcare dollars in several studies. Baser et al. (2014), found that prescription opioid abusers from 2006-2009, experienced total annual healthcare costs of $28,882, while non-abusers cost $13,605, which is a difference of $15,277.

Similarly, Kirson et al. (2017), found that opioid abusers experienced annual health care costs of $14,810 when compared to non-abusers. Ronan & Herzig (2016) found that in 2012, inpatient charges for opioid abuse reached nearly $15 billion and $700 million for infection related cases associated with opioid abuse. Shei et al. (2015), found that for high cost opioid abuse patients, medical costs were $89,177 versus $11,653 for lower cost patients.

More specifically, Inocencio et al. (2013), found that the average cost for opioid related treatment at an emergency room is $1,832. In addition, Xie et al. (2014), found that patients who received...
opioids in an emergency visit had higher overall healthcare costs ($49,766), compared to patients who did not ($19,875). Moreover, Hsu et al. (2017), identified that heroin related admissions caused total in-patient cumulative costs to rise $4.1 million a year, compared to $46.0 million a year for prescription opioid related admissions between the years 2001-2012.

Two studies in particular, looked at hospital costs related to opioid abuse by patient insurance status and found that Medicare and Medicaid had the highest per-event charges when compared to private insurances.5,12

Societal Implications

The opioid crisis also affects social welfare in the United States. Opioid abuse/dependence is perhaps underdiagnosed, as many people may chose not to seek help or treatment out of fear or stigma. Three studies explored the social consequences of this issue.7-9 In 2009, Inocencio et al. (2013) found that productivity losses based on absenteeism from opioid related emergency room visits and hospitalizations cost $335 million with heroin accounting for $79 million and prescription opioids at $256 million.

Physicians play a key role in preventing the spread of opioid addiction. They must be able to recognize potentially addictive and drug seeking behavior and carefully assess their patient’s medical history prior to prescribing these potentially harmful medications. Drug monitoring programs can assist in reducing “doctor shopping.” Although not a solution to the opioid epidemic, increased access to Narcan can potentially save lives and perhaps reduce healthcare costs by lessening the severity of the hypoxia.8

Moreover, health insurance is another social problem related to the opioid epidemic. Hsu et al. (2017), found that between the years 2001-2012, 35% of heroin related admissions and 15% of prescription opioid related cases had no health insurance. A lack of insurance is costly for the Healthcare Delivery System and is linked to other societal concerns such as unemployment and poverty. Of those patients that had health insurance, Medicaid was the most common for heroin related cases and Medicare for prescription opioid cases.8

Another societal aspect to consider is the geographic region and hospital location of opioid use and abuse. Hsu et al. (2017) found that between the years 2001-2012, heroin related admissions decreased in the Northeast and increased in the Midwest, while prescription opioid admissions remained stable and more prominent in the South throughout the study. Similarly, Xie et al. (2014) found that prescription opioid patients were more prominent in the South. Heroin related admissions occurred in more urban hospitals while prescription opioid related cases had a shift towards urban hospitals over the 12-year study (Hsu et al., 2017).8

CONCLUSION

Prescription opioids and heroin are drugs that pose a high risk for addiction. In nearly two decades, there has been significant increases in opioid-related deaths in our nation. One of the contributing factors to this public health concern is the over-prescribing of opioids. There are clinical, economic, and societal consequences associated with the opioid crisis. In conclusion, based on this literature review of ten observational studies, it can be summarized that the opioid crisis has a significant financial impact on our healthcare delivery system with increased emergency visits, in-patient admissions, mortalities, and outpatient services. A Nationwide Comprehensive Strategic Plan must be developed and implemented to address and assure the Opioid Crisis is minimized, the health care related costs decreased and the mortalities avoided.

This literature review has some limitations. This review was completed by one person and it is possible that different reviewers would have synthesized results differently. Only ten articles were included in the review based on the author’s eligibility criteria. It is possible that high quality publications were missed due to the search criteria. The studies were all observational studies and it is possible that higher quality publications were missed. Moreover, it may be difficult to generalize results, as each publication had different groups and methodological approaches, making it challenging to identify significant relationships across all the studies.

Additional research is needed to determine the differences between prescription opioid, heroin, and abuse, misuse, and dependence as diagnosis coding was a challenge in several of the studies. Moreover, future research should replicate these studies to further strengthen the evidence of the findings.

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REFERENCES

11. Lockwood, C. J. (2018). Why is there an opioid crisis? Like the road to hell, the road to the opioid crisis was paved with good intentions. Contemporary OB/GYN, 63(2), 6-10.
I began my nursing career in the emergency department at a local hospital in Louisville, Kentucky in the early 90s. I worked in the emergency department as a technician and nursing extern while I was completing nursing school. Throughout the 16 years I saw many patients circulate through our doors. I always prided myself on my thoroughness as I reviewed discharge instructions with our patients. I made sure every bullet was covered and all boxes were checked. If a patient was leaving on crutches I asked them about whether they had stairs to navigate. If a person was being discharged with a new medication I asked them about their understanding of the dosage and whether they understood they must take the medication with food or it could upset their stomach.

I never asked them if they had food at home or if they had access to food. It wasn’t something I was taught in nursing school or in the many hours of training I had before they let me practice emergency department nursing on my own. I didn’t know to ask those questions and I didn’t realize that maybe there were reasons for many of our patients visiting us so often. It didn’t occur to me that maybe they didn’t have any food in their pantry and possibly that meal I ordered for them from the cafeteria was the only meal they would have that day.

When I was a nursing student I never heard the term social determinants of health. I never learned what the term meant or how social determinants of health can impact patients’ health outcomes. Social determinants of health are the conditions in the environment in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.¹

In the last few years, physician practices, schools of medicine and nursing, and even insurers are beginning to examine how these barriers impact patients and their health. Examples of social determinants being addressed are access to food, safe housing, and transportation.

Health is more than what happens inside the physician’s office or hospital. “We know that conditions in which people are born, grow, live, work and age, known as the social determinants of health, combine together to affect the health of individuals and communities.”²

Food insecurity is a social determinant of health that has a huge impact on the health and well-being of an individual. The USDA defines food insecurity as a lack of consistent access to enough food for an active, healthy life.³ Food insecurity is not something that can be seen just by looking at someone. In fact you may know someone who is food insecure and not realize it. Feeding America has found that one in eight people in America struggle with hunger.⁴ There are two simple questions that can be asked of patients around food insecurity. The Hunger Vital Sign™ identifies individuals and families as being at risk for food insecurity if they answer that either or both of the following two statements is ‘often true’ or ‘sometimes true’ (vs. ‘never true’):⁵

“Within the past 12 months we worried whether our food would run out before we got money to buy more.”

“Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.”

By asking the Hunger Vital™ sign questions you can determine if an individual is at risk for food insecurity and can then assist them in getting connected to their local food bank. Groups like Feeding America or local food banks can assist people to obtain food. In many communities benefits such as SNAP are available to

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**Summary**

Nurses have the ability to address social determinants of health in patients and refer those with health barriers to resources. Doing so can have a long-term impact on patient health.

**Key Points**

- Social determinants of health impact the health outcomes of individuals.
- One in eight Americans is food insecure.
help individuals who are food insecure. SNAP helps low-income people buy the food they need for good health."

If I were an emergency department nurse today I would ask every patient I discharged whether they had food in their pantry. I would ask them whether they had food they could eat before taking their medicine. If I did maybe I wouldn’t have seen that individual who had uncontrolled diabetes as much as I did and he might not have been re-admitted to the hospital as often. Not only could I help my patients heal from a fracture but I might have been able to change the course of their long term health by connecting them to a local food pantry or referring them to a local resource that could assist them in applying for SNAP benefits.

I feel fortunate to be able to do the work I am doing now and share the knowledge and resources I have learned at Humana through our Bold Goal population health work. I still have much to learn but am excited I can share this information with my nursing peers and other clinicians. I am confident that addressing social determinants of health in individuals can help improve health outcomes and change the world just a little bit each day.

Angela D. Wolff, RN, BSN, CCM is the Director of Business Integration & Engagement on the Bold Goal Population Health team at Humana Inc.

REFERENCES
Population Health Management Is a Primary Care Priority
Nancy Rudner, DrPH, APRN

PRIMARY CARE IS THE CORE OF HEALTH CARE AND of patient engagement, central to clinical outcomes, and key to the efficient and effective functioning of the health sector. As a key access point of care, primary care can provide prevention, chronic disease management, continuity, and care coordination. Primary care is well positioned to develop and support patient and family engagement, an important component of health. Population health management strategies guide primary care practices toward achieving Triple Aim: improving patient experience, improving outcomes, and bending the cost curve.

Chronic disease needs drive 40% of all primary care visits, 50% of primary care visits for those 65 and older, and almost 60% of Medicaid and Medicare primary care visits. The highly prevalent chronic conditions of hypertension, diabetes, heart disease, joint problems, and depression are among the top 10 reasons for a primary care office visit.¹

Primary care has significant challenges. Care is often fragmented. Opportunities for patient education, guidance, and support are limited. Patients may not fill prescriptions, get lab tests done, or refill medications, compromising outcomes. Specialty consults are often hampered by inefficient referral processes and care gaps. Medication can be particularly troubling, too often resulting in emergency care for preventable medication misadventures. Care transitions present another set of care gaps, needs, and risks for compromised outcomes, including readmissions. Even with the best care in the patient office visit, many other factors influence patient outcomes.

Population health management incorporates needed resources and services into primary care to support patient care. Data can be leveraged to put a laser focus on identifying individual patients at risk, care gaps, and needs as well as opportunities for improvement. Care coordination, disease management, and coaching support patients with chronic conditions and care transitions. Behavioral health integrated into primary care can address self-care issues. Clinically integrated networks facilitate referrals, consults, and collaborations. Population health management can provide the structure for addressing the social factors influencing health. Achieving Triple Aim requires the alignment of patient, provider, and system processes in primary care for best outcomes.

As value-based purchasing (VBP) continues to replace fee for service arrangements, the need for primary care practices to incorporate population health management to achieve better outcomes continues to be a priority. The Centers for Medicare and Medicaid Services (CMS) supports VBP with multiple payment reform strategies, including Accountable Care Organizations, Merit-based Incentive Program, Medicare Share Savings Program, and Comprehensive Primary Care Plus. A population health management strategy can guide NP primary practices to maximize outcomes, achieve Triple Aim, and benefit from VBP.

Nancy Rudner, DrPH, APRN is a faculty member of the George Washington University School of Nursing.

REFERENCES
FDA Approves First Treatment for Advanced Form of the Second Most Common Skin Cancer

The U.S. Food and Drug Administration approved Libtayo (cemiplimab-rwlc) injection for intravenous use for the treatment of patients with metastatic cutaneous squamous cell carcinoma (CSCC) or locally advanced CSCC who are not candidates for curative surgery or curative radiation. This is the first FDA approval of a drug specifically for advanced CSCC. Libtayo works by targeting the cellular pathway known as PD-1 (protein found on the body’s immune cells and some cancer cells). By blocking this pathway, the drug may help the body’s immune system fight the cancer cells. Read more at goo.gl/LDSRrh

CMS Provides New Flexibility to Increase Prescription Drug Choices and Strengthen Negotiation for Medicare Enrollees

The Centers for Medicare & Medicaid Services (CMS) issued a memo today to Medicare Part D plans, which cover prescription drugs that beneficiaries pick up at a pharmacy, offering plans new tools and flexibility to expand choices and lower drug prices for patients. Currently, if a Part D plan includes a particular drug on its formulary, the plan must cover that drug for every FDA-approved indication, or patient condition, even if the plan would otherwise instead cover a different drug for a particular indication. The requirement to cover drugs in this manner can discourage Part D plans from including more drugs on their formularies and limit... Read more at goo.gl/JwXcjo
Congratulations to the Newly Certified Managed Care Nurses (CMCNs)!

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**AUTHOR GUIDELINES**

I. **Original Articles**

1. Each article should clearly state a problem or challenge facing today’s healthcare environment, discussion of possible strategies for solution or implementation, and reach a conclusion. Solutions or implementation strategies are expected to be reasonable, original thoughts supported by data. All statistical data and information not public knowledge should be referenced from a reliable literary source.

2. Articles should be relevant to United States managed care, and have sound and timely references.

3. Articles can include topics of interest focusing on employee or worker-type concerns relevant to membership such as work-life balancing, reducing stress, managing personal responsibilities, avoiding burn-out, dual-role caregiving of parents and children issues, managing technologies and social medias, etc.

4. No articles that endorse services or products should be submitted.

II. **Editorial Review and Processing**

1. Peer Review: All articles submitted will be reviewed by the Editorial Review Board. Peer-reviewer identities and author identities are kept confidential during this process.

2. Rejected articles will not be returned to authors unless specifically requested by the author in advance. Original illustrations, photographs, and slides will be returned.

3. Editing: Accepted articles are copy-edited for style, grammar, clarity, and length. At the editor’s discretion, particularly if substantive changes are made, articles may be returned to author for final review. Authors are responsible for all statements made in their work, including changes made by the editors and authorized by the author.
III. Article Preparation

1. **Biography:** Every article should include a brief biography of the author(s) (< 50 words) including academic/corporate affiliations. The name of the author(s) should be bold face and include academic degrees as follows:
   Natalie Irish, RN, MSN, CMCN (etc.)

2. **Abstract:** *JMCN* abstract style includes a one or two paragraph “**Summary**” followed by “**Key Points,**” a series of quick-read bulleted items. The total word count should be no more than 275 words.

3. **Headings**
   “A” heads should be in bold face, flush left and initial caps.
   “B” heads should be in bold/italic face, flush left and initial caps.
   “C” heads should be underlined, flush left and lower case.

4. **References:** References should be double-spaced and consecutively numbered as they are cited in the text (the number of the reference should appear in superscript within the text). The article should be fully referenced within the text. References in incorrect format could be grounds for rejection of the article. If you need assistance in producing correct references, the editorial staff will be happy to answer any questions. References should follow the format of the *AMA Manual of Style*, 10th edition. Sample references are as follows:

**Books**


**Articles**


5. **Exhibits:** Tables and figures should be typed and consecutively numbered as they are cited in the text. Each table and figure should have a title. Title should be flush left, in bold face with initial caps. Source for the table or figure should be identified in the title with a superscript number and be listed as a reference.

**Exhibit 1. Number of Inhabitants Per Region in France**

<table>
<thead>
<tr>
<th>Region</th>
<th>Male Population</th>
<th>Female Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bordeaux</td>
<td>14,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Bourgogne</td>
<td>120,000</td>
<td>234,000</td>
</tr>
</tbody>
</table>
6. **Abbreviations and Acronyms:** On first reference, spell out the word and place the abbreviation or acronym in parentheses. Verify correct usage of all abbreviations and acronyms.

7. **Drug Names:** In general, use generic names for drugs. If the author wishes, the brand name may be included in parentheses when the generic name is mentioned for the first time. Drug names should be initial caps only. If the article is CE approved, the author must work with the AAMCN CE committee to complete all processes required by AAMCN and the American Nurses Credentialing Center (ANCC). Please contact us for more information.

8. **Punctuation & Miscellaneous:**
   - Use commas to separate elements in a series, and also use the serial comma before the conjunction (e.g., patients, physicians, and medical providers)
   - Indent bullet points
   - Spell out numbers under 10. Use numerals for 10 and higher (e.g., The study results indicated that six persons were salt-sensitive; out of the 120 patients studied, six were insulin-resistant).
   - Always spell out numbers at the beginning of a sentence (e.g., Twenty-five of the 30 patients enrolled suffered from hypertension).
   - Spell out the word “percent” vs. using the symbol (%) in text (e.g., 50 percent of the population.) The percent symbol is acceptable in tables and figures.
   - Use initial caps vs. all caps for company names (e.g., Lederle Laboratories).
   - Do not use hyphens between numbers within the text. (e.g., 12 to 16 patients; not 12-16 patients).

**IV. Submission Checklist**

All article submissions should include the following elements:
- The author(s) short biography
- Article summary and key points
- Contact numbers (phone and fax), complete mailing address, and e-mail address for designated corresponding author. This information should appear on the title page, along with the word count for the article and any acknowledgments for research and/or project support.
- Electronic version of the article as a Word Document or Rich Text Document emailed or sent by DropBox to April Snyder at asnyder@aamcn.org.

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