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Hospital to Home: Supporting Transition from Neonatal Intensive Care
Janet Treadwell, RN, PhD
Corey Sigue, BS
Ekiria Collins, MPH
Angelo Giardino, MD, PhD ....................................................... 4

Connecting Patients and Financial Resources:
The Value of the Financial Advocate
Sheryl A. Riley, RN, OCN, CMCN .............................................. 7

Telehealth in the Age of the Affordable Care Act:
Impact on Integrated Care Coordination
Stefany H. Almaden, PhD, RN, MSN, CCM, CPUM, CMCN ..............10

Transformation: The Future of Nursing and Managed Care
Nancy Rudner Lugo, DrPH, MSN .................................................. 15
Hospital to Home: Supporting Transition from Neonatal Intensive Care
Janet Treadwell, RN, PhD; Corey Sigue, BS; Ekiria Collins, MPH; Angelo Giardino, MD, PhD

Summary

Barriers to effective hospital to home transition for neonatal intensive care graduates include inadequate caregiver preparation and lack of informed community providers. Use of a comprehensive program to educate caregivers and communicate to the receiving care team prior to transition may improve health outcomes, as measured by readmission rates and timely pediatric follow up care for these fragile infants. Following support in development of the Safe Passages program at Texas Children’s Hospital, Texas Children’s Health Plan implemented the health coach model across four institutions. Findings showed a program of effective communication techniques and individualized education was able to meet the challenging issue of optimizing outpatient continuity of care for neonatal intensive care unit graduates across geographic settings.

Key Points

- Many factors such as travel obstacles and large numbers of follow up visits for neonatal intensive care graduates translates to lower adherence rates.
- Use of comprehensive discharge programs, including the use of health educators, have been able to reduce readmission rates as much as 30%.
- Larger numbers of appointments required for a fragile newborn who may need to be seen by numerous specialists translates to lower adherence, a major concern for NICU discharged infants.

WHILE ADVANCES IN CARE AND TECHNOLOGY TO support pre-term infants has improved health outcomes and reduced mortality, improvement in successful transition of newborns from the inpatient environment has not kept pace with the technology curve. One out of every eight, or over 20,000 neonates, are discharged annually from the neonatal intensive care unit (NICU) presenting a potential risk of readmission with associated clinical and financial cost.1 As of 2010, the average cost of medical care for the first year of life was $32,000 for pre-term infants who receive care in a NICU setting compared to $3,000 for term newborns.2 Readmission rates for these NICU discharged infants can be as high as 40% for associated disease states, adding to clinical concerns and overall expense.3 Inconsistent discharge standards applied in neonatal intensive care settings based upon physical parameters and weight gain can impede effective transfer home.4 While the foundational elements of obtaining a pediatrician appointment and being observed successfully performing care measures are addressed, other discharge areas are sporadically addressed. In addition, support to make sure the mechanics of the visit can occur and clear expectations for home care is not consistent. This places infants at risk of poor health outcomes and/or readmission.

Texas Children’s Health Plan, providing care to over 390,000 members, had a concern about successful transition of NICU graduates in their population. Especially considering the disparity in incidence of neonatal intensive care (NICU) admissions, being two to three times higher in populations of poverty such as those covered by Medicaid and managed by the health plan.2 The concern extended to caregiver understanding and competency to provide care as well as the coordination and readiness of the receiving provider community, stemming from insight gained from participation in the Safe Passages investigation at Texas Children's Health Plan.3

Once discharged, noncompliance with advised pediatric appointments becomes a potential risk even if the appointment was scheduled at the time of discharge. The risk of visit noncompliance increases with the number of visits required.6
care is also important for successful transition. Time limitations may prevent the neonatologist or intensive care staff from providing the desired level of communication for caregiver support. Emotional status of the family related to hospitalization may also interfere with the uptake of education during times available for the hospital staff. However, parents desire clear communication about their infant to assist in setting appropriate expectations for the child’s prognosis and their role in care.1 Approaching the few days prior to discharge as the time to exchange educational papers, written instructions and sign off on caregiver competency is prohibitive to a successful transition. Utilization of a trained educator/transition coach to deliver information in an individualized manner, being cognizant of language and cultural preferences, can facilitate successful transition. The educator can use a flexible schedule to connect with families. Content can be individualized and segmented as needed. In addition to verbal exchange and handouts, use of technology familiar to the family (such as cell phone video) to record discharge instructions, can provide access to information once the family unit is home.9 Internet resources can be shared with the family, providing an opportunity for a guide to trusted sites. The March of Dimes website section specifically for families with babies in the NICU (http://marchofdimes.org/baby/in-the-nicu.aspx), and Kids Health Primer on Preemies (http://kidshealth.org/parent/growth/growing/preemies.html) are two examples.

The health educator/coach who assesses access to care, establishing a pediatrician, expectations of care requirements, and other environmental barriers may be able to provide assistance beyond the focused planning for the newborn’s specific needs at discharge. An illustration of an area where the health educator (coach) can play a valuable role during the transition education period is with a mother who smoked during pregnancy. There is evidence that mothers who smoked during pregnancy are more likely to continue smoking after birth and second-hand smoke is associated to an increased risk of readmission.10 Use of motivational interviewing during this coaching period can impact behaviors which could influence the possibility of a readmission due to secondhand smoke.

The education portion of a comprehensive transition plan carried out by a trained educator has the result of better caregiver understanding and compliance.11 Institutions that invest in a comprehensive discharge planning program for their NICU must have administrative support as collaboration is required of providers working in the NICU as well as receiving service providers in the community.12 Development of policies and procedures as well as adoption of a protocol such as ‘Transitioning Newborns from NICU to Home: A Resource Toolkit’, helps to provide a program of consistency.5

Quality Intervention

The Texas Children’s Health Plan used intervention to support parents and provide the receiving pediatrician briefing for successful infant transition with use of a health coach from the health plan. The health plan was able to initially utilize the health educator who participated in the Safe Passages curriculum testing to continue education at the initial facility and expand it to three other high volume delivering facilities in the health plan network. This role delivered onsite or telephonic visits to the Level 4 neonatal intensive care sites (NICU) at four target facilities. Agreement was obtained from the relevant hospital administration and care management staff at the contracted facilities. Hospital staff was in agreement with the presence of the health educator, goals of the program, and educational material/curriculum content.

The health educator received daily notice of admissions of health plan members to Level 4 NICU through the health plan utilization management application. An introductory phone call or an onsite visit was the mode of introduction to the parent(s). The health educator explained the program and requested voluntary participation in the educational sessions. Upon agreement of the parent(s), education modules were introduced in face-to-face sessions, or if necessary, telephonically. The educational information was presented across one to three sessions. Three sessions was explained to the parent as optimal to enable content to be absorbed and allow questions to be answered. The health educator huddled with NICU staff during onsite visits to be abreast of changes in treatments that could influence care at discharge or need to select a different pediatrician for ongoing care, and to understand the planned discharge date. The health educator assisted parents with tools to select a pediatrician, secure an appointment, and establishing a plan to achieve appointment success by addressing barriers (transportation, babysitter for other children). The health educator also supported, upon selection of that pediatrician, a transition phone call between the neonatologist and the receiving physician in addition to routine paper discharge information. Educational content was presented in a module format, using evidence based information which has since been created into a resource toolkit by Agency for Healthcare Research and Quality.9 Module presentation, and the number of parent sessions was modified based upon the desire of parent(s) and changes in discharge dates.

Using 2012 data as a baseline measure for utilization activity, families of infants admitted to Level 4 NICU in 2013 in the four selected facilities were offered the educational coaching opportunity. Readmission activity within seven days of discharge, success of a first pediatric appointment within fourteen days of discharge were elements gathered due to their bearing on identification of a quality discharge transition for this vulnerable population of NICU ‘graduates.’

Quality Improvement

Families were eager to engage in discussion about their infant transitioning home. No family declined the offer of an educational intervention. The total number of families engaged was 471 with the comparative 2012 population of 405 infants (Figure 1). The total number of readmissions within seven days across the four facilities in 2013 was twenty one. Readmission activity in seven days for infants graduating from Level 4 NICU settings between 2012 and 2013 showed a significant difference when applying the test of two proportions, p=.046. The two larger admitting facilities showed the greatest change. Adherence to follow up appointments with a pediatrician was measured through review of claim data received by the health plan, indicating a date of service within 14 days of discharge. There was 95% adherence for physician visits in the 2013 for families receiving the intervention compared to a 93% 14 day visit adherence in 2012.

Discussion

The purpose of this quality intervention was to address the impact of education and coordination activity with parent(s) of infants with Level 4 NICU admissions on success of transition to home. Success being defined as absence of readmission within seven days and successful first pediatric office visit within 14 days.
An important aspect of the education was sharing expectations of discharge care needs, evaluating parent and social system support needed to deliver required care, and selection of a pediatrician that would be in agreement caring for a child with the specific needs of this particular infant. It was found that many parents needed to change from a previously selected pediatrician as that professional did not agree to accept children with special healthcare needs in their panel. Provi0ng the coordinating link for the family to appropriate community services was important to parents who found the prospect of managing caregiving, multiple appointments and vendors was described as ‘scary.’ An additional facet of the education noted as positive by parents was aligning expectations of the family to the health and service acuity of the infant and explaining the need to be the voice of their child when advocacy was needed.

Conclusion

Use of comprehensive discharge programs have been able to reduce readmission rates as much as 30%, through family engagement and aligning appropriate medical, rehabilitation and social services. This quality intervention informs of the potential benefit in delivering individualized education to families with children in NICU to improve health appointment adherence and impact readmissions using a collaborative team of community providers, hospital teams and the health plan. Use of an integrated team approach is a successful strategy for successful transition. Education and communication reinforces the family role in seeking health care services and self-management. Appropriate educational materials exist to implement a structured plan that can be individualized to provide family-centered care by a health plan or facility. Utilizing evidence-based tools to provide consistency in hospital to home transition for NICU graduates may have the ability to decrease readmissions. An effective “hand-off” to a receiving pediatrician and clearly educating caregivers on roles and expectations is an opportunity that can be jointly explored by facilities and managed care plans as a way to team for true patient-centered care.

Janet Treadwell, RN, PhD is Director of Care Coordination at Texas Children’s Health Plan in Houston Texas. Areas of interest are population health and children with medical complexity.

Corey Sigue, BS is a Research Specialist at Texas Children’s Health Plan. Areas of interest are in delivery system design, program outcomes, and analytics.

Ekiria Collins, MPH is a Health Educator and Manager of Health Care Services Research at Texas Children’s Health Plan.

Angelo Giardino, MD, PhD is Professor and Chief of the Section of Academic General Pediatrics at Baylor College of Medicine and also serves as Senior Vice President and Chief Quality Officer at Texas Children’s Hospital in Houston Texas. Interests include care to vulnerable populations, population health and quality improvement.

References

Connecting Patients and Financial Resources: The Value of the Financial Advocate

Sheryl A. Riley, RN, OCN, CMCN

Summary

Many hospitals and offices have “financial advocates” to help with planning and paying for treatments, however, they do not have nearly enough. The catastrophic costs for cancer patients can become overwhelming with not enough help available to relieve stress and debt. Cancer treatments can even be missed if there is a lack of funds. The role of the financial advocate in oncology settings can decrease anxiety and depression and influence the completion of treatment.

Key Points

• Financial stress is detrimental to the treatment of cancer patients
• Oncology practices should begin to look at creating a position for a financial advocate within their office

OUR CURRENT ECONOMY AND HEALTH CARE SYSTEM

i.e. Affordable Care Act, Accountable Care Organization, bundled payments and alike has given birth to a new member of our health care team, “Financial Advocate” (FA). Even though many hospitals and large clinics have some form of patient advocate, navigator and or social workers, not all of these professionals are trained in the complex financial issues of a cancer patient. Many of these wonderful professionals are spread too thin, seeing far too many patients and dealing with more than just the disease of cancer therefore becoming an expert on the complex nature of cancer diagnosis, co-payment, co-insurance, drug assistance, financial assistance and more is much too difficult. Most facilities only have one advocate that serves many purposes, again creating further difficulty in being an expert in all types of financial assistance impossible.

The cost of having cancer and or surviving cancer presents many challenges for the patients, caregivers, families and providers. In a survey conducted in 2012 by the ACCC, Association of Community Cancer Centers, “Cancer Care Trends in Community Cancer Centers”, 95% of respondents reported that they were seeing more patients who needed help with co-pays and or co-insurance. Community cancer centers also reported that they were spending increased time assisting patients with identifying and accessing resources to help with costs related to medications, missed work hours, transportation and more.

The numbers tell the story, a 2009 survey conducted by the Association of Oncology Social Work (AOSW) revealed that more than one half of cancer patients indicate cancer costs negatively impact their focus on recovery.

According to the survey, 66% of patients with major financial challenges suffer depression or anxiety, 29% delay filling prescriptions due to financial pressures, and 22% skip doses of their medications. Sixty-three percent of oncology social workers surveyed said financial issues reduce patients’ compliance with their cancer treatment even though that treatment is key to their recovery. Additionally, 40% of patients reported depleting their savings, almost 30% reported dealing with bill collectors, and 54% of those handling a major/catastrophic financial burden said it had become more difficult in the past year to afford treatment.

Furthermore, 68% of cancer patients and caregivers surveyed reported that the patient is experiencing financial hardship due to medical bills, and 55% of all cancer patients surveyed said the stress of dealing with costs negatively affects their ability to focus on their recovery.

Recently, I had the opportunity to attend a conference sponsored by the ACCC about Financial Advocacy. I was delighted to see so many people from all over the country in attendance as well and I was excited to speak with as many as possible to learn more about what they do, how they do it and how they are supported by their facilities. It was a diverse group, some of the FAs were lay persons who got involved due to a personal experience and then decided to make it a career, others were nurses and social workers and still some had degrees in education, finance and communications. I assumed that most FA would be nurses and social workers (SW) but I was wrong, the majority of the persons employed across the country in the job was a lay person with a high school diploma who want to advocate for patients.

During the presentation they acknowledged that the bulk of the work is being done by lay persons across the country with little or no college education. I find this fascinating and reassuring at the same time; however there are a few advocating for advance degrees in this field but I believe the mix of clinical, psychosocial and non-clinical professionals working in concert is the best combination
for the patient and the family. What I also learned was that not only hospitals and clinics where hiring FAs to assist their patients, but large physician practices were jumping on board as well.

Other exciting topics that came up in my conversations with FAs were around how many patients they serviced and how they are supported. What was fascinating was that some facilities have disease specific advocates, advocates for drug assistance only and/ or only a handful had specific advocates for non-medical related expense and issues. The majority of what I heard throughout the day and in further research was that regardless of who is preforming the job, there are never enough of them to meet the needs of our patients. Skyrocketing health care costs, drugs and physicians, time off from work, health care premiums, copay and co-insurance, possible loss of income, meals, transportation and other services; all of this is overwhelming to a person just diagnosed with cancer.

Comprehending a cancer diagnosis is not something anyone wants to deal with, many times not even taking the time to think of the cost. The AOSW research found that only 36% of patients have discussed the cost of treatment with their oncologist, and only 16% of patients and caregivers report that they believe their oncologists even think about the financial implications of the treatments they prescribe. In fact, only about one half of patients feel comfortable speaking with health professionals about financial issues. Too often the physician does not address cost with the patient until after treatment is underway and that patient receives their first bill. This can be devastating to the patient and hinder the success of treatment, causing incredible stress, anxiety and depression. Findings show that when initially diagnosed, nearly all cancer patients, including those with blood cancers such as multiple myeloma, consider effectiveness before all other factors when determining their treatment plan, ranking the cost of treatment last in their decision-making process. However, new data show that the stress related to finances can impact compliance and potentially present serious consequences.

Consider these statistics from the Association of Oncology Social Work’s recent survey:
• Treatment costs negatively impact the ability to focus on recovery for 87% of patients with catastrophic/major financial burdens due to cancer treatment, and 75% of these patients constantly worry about financial issues due to cancer treatment.
• Almost one half (46%) of patients who have experienced a financial burden from their cancer have cut back on necessary expenses such as food to pay for cancer treatment.
• Twenty-four percent of respondents indicated that they suffered a relationship issue in their efforts to afford cancer treatment.
• Six percent sold a home or relocated due to the financial stress and 3% experienced a home foreclosure.
• Fifty-six percent of patients were not at all prepared to handle the financial burden of cancer, while only 7% indicated they were completely prepared for it.

Physicians are faced with many challenges in diagnosis, treating and caring for their patient with cancer but the financial burden of their patients can hinder the care and treatment of each and every person they see. Therefore, oncology practices should begin to look at creating a position for a financial advocate within their office. These wonderful people know how to speak with patients and their families about all the topics that no one else wants to, they also bring value by assisting the oncology practice in meeting the growing financial concerns of their patients, streamlining the billing, appeals, denial, verification and drug assistance or replacement programs. Easing the patient’s financial concerns about treatment has been proven to decrease stress, anxiety and depression as well as patients should and will maintain treatment regime because they feel that the finances are taken care of and they can focus on recovery. FAs pay for themselves 10 times over when patients can complete treatment, not miss doses, feel confident about the financial aspects of care, decrease stress, anxiety and depression.

Sheryl A. Riley, RN, OCN, CMCN is a Managing Partner at Clarion LLC, a Care Management and Consulting company.

References:
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<thead>
<tr>
<th>BENEFITS</th>
<th>VALUE</th>
<th>COST TO MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online CEUs</td>
<td>$1,300</td>
<td>FREE</td>
</tr>
<tr>
<td>Quarterly Webinars</td>
<td>$740</td>
<td>FREE</td>
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<tr>
<td>AAMCN Pre-Conference</td>
<td>$125</td>
<td>FREE</td>
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<tr>
<td>Spring Conference</td>
<td>$695</td>
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<tr>
<td>Journals</td>
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<td>Career Center</td>
<td>priceless</td>
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THE WAVES OF CHANGE IN HEALTH CARE ARE reaching epic heights. We have seen cycles of power shifts within the industry since the early 80s from managed care organizations to provider groups, then to hospitals, and back to payers and communities under coordinated care initiatives. However, we are not even scratching the surface of how health care delivery should look like or its impact on managed care nurses. My purpose in this article is to demonstrate a fit between the Affordable Care Act (ACA), Telemedicine, generational differences of practitioners, and cost-effective care for chronically ill, at risk patients through a metasynthesis of current literature. In this article, I shall also explore these changes and their impact on nursing practices, following a historical overview considering references to anti-trust laws that many in the industry refer to when debating current practices under the ACA.

Historical Background

The Sherman Act of Anti-trust Laws was passed in 1890 to control conglomerate-power that interferes with trade and reduces competition.7 Within the health care industry, that reduces competition through a monopoly of select markets leaving patients with minimal choices for health services delivery. To better control the aftermath of the Sherman Act, the passing of the Clayton Act was in 1914 to make amendments to the Sherman Act by ascertaining certain prohibitions not addressed earlier are controlled. Such prohibitions included “mergers and interlocking directorates” that may entail having the same person or entity to make critical business decisions “for competing companies”.7 In that respect, Section 7 of the Clayton Act prohibited practices that reduce competition and create a powerful monopoly instead.

The next key legislative update was the passing of Stark Law in 1989, prohibiting self-referrals and honing in on conflict of interest concerns that may impact patients’ rights to good and appropriate care. Stark Law I was passed under OBRA 1989, Section 1877 of the Social Security Act, and it was limited to lab services.4 This was followed by Stark Law II in 1993, when Congress expanded the prohibition to include services under The Department of Health & Human Services (DHS) and applied certain aspects of the Physician Referral Rule to the Medicaid program as well.4 These services include: physical, speech and occupational therapy, radiation therapy, durable medical equipment, inpatient and outpatient services...etc. As the health care system went through additional changes, the Medicare Self-referral Disclosure Protocol (SRDP) was published on September 23, 2010 pursuant to Section 6409(a) of the Patient Protection and Affordable Care Act (ACA). The SRDP set a process for service providers and suppliers to “self-disclose actual or potential violations of the physician self-referral statute” forcing huge fines for violations.4

The ACA Signing into Law in 2010

On March 23, 2010 the most historical event for health care reform, the Patient Protection and Affordability Act (ACA) was passed. The ACA marked the “start of a golden age for ambulatory care nursing”.8 While stakeholders, lobbyists, Medical associations, and the like were debating the ACA, many pleaded for sanity under the old adage “the train left the station”. It was
time to figure out how to get on board if we were to continue the journey of care delivery and focus on issues that matter most, that is, patient-centered care. There was no other option considering the tax-penalties that were applicable effective 2015.

With the passing of the ACA, many debated its conflict with the past antitrust laws. Reasons included mainly consolidation of care providers under the care collaborative, and patients having the same provider throughout the care continuum. Others saw this as an opportunity. In order to safely deliver good care while keeping the patient at the center, focus should be placed on care coordination and integration of all aspects of health care delivery. A provider may elect continuity at a lower level of care setting while giving choice options to patients or family with disclosure if there are conflict of interest issues. The provider can also disclose that s/he may not be able to continue providing care at a different location and request authorization to information exchange to transition care to a different provider, should the patient or family elect a different setting. For patient populations that transition to, or are simply in a home setting that would benefit from tele-monitoring and management, access to effective care hold telehealth as a strong potential for quality coordinated care. This connection between ACA and telehealth is explored further next in a synthesis of health services studies that addressed telehealth.

**Impact of ACA on Telehealth**

Under the ACA, telehealth holds a very promising potential to not only improve access to care but also to increase the value of health care services like never before.1 Hospital telehealth adoption varies by state and by organization and licensure policies contribute to that variance.1 Regardless of such barriers to the use of telehealth, the reality is that it provides valuable monitoring, data and quality metrics, and access to health services that are often limited by location and timing of the need for health care.

Weinstein; Lopez; Joseph; Erps; Holcomb; Barker; & Krupinski (2013) stated that advances in telehealth services provided coverage of gaps in services such as night time radiology, urgent care whether after business-hours or niche services like telestroke services and mandated services in correctional facilities, as well as video-enabled chart reviews or rounds. Covering such gaps in care and the value of such on-demand services are positing a reality that attests to the value of telehealth in removing barriers to care and its worthiness of funding. The authors further asserted that while mobile health is growing exponentially, Medicare lags behind Medicaid in reimbursement and interstate licensure issues complicate the delivery of telehealth services.11

In a comparative study, Baker, Johnson, Macaulay, and Birnbaum (2011) explored integrated telehealth and care management programs for the chronically ill. Medicare beneficiaries under the assumption that barriers to providing effective treatment such as a fragmented delivery system and lack of continuity of care, can be mitigated using telehealth. The researchers used the “Health Buddy Device”, a handheld device linked to care managers via telephone, where patients responded to daily questions about their symptoms, vital signs, and health behavior. Responses were uploaded to a web-based application for review and appropriate interventions ensued based on “exceptions” for CHF and COPD patients, and diabetics. The study demonstrated that the technology platform was associated with improved care coordination, less health services’ spending, and lower mortality rate. A major highlight in this study pointed to the value of patient engagement given that only 37% of the intervention group was engaged in reporting.2

Similarly, Courtney, Lingler, Mecca, Garlock, Schulz, Dick, and Olshansky (2010) tackled the issue of community-based telehealth Kiosks as an option to access care through virtual visits to providers of care. Courtney et al. examined telehealth kiosk service as an economically preferable option for older adults with financial and mobility limitations through an institutional review board (IRB) approved study of residents of a HUD-subsidized senior low-rise apartment housing (2010). Study participants received free care management through a community program, monthly blood pressure checks and health education, and a planned telehealth kiosk implementation that included remote access to blood pressure and weight measurements. Findings clearly demonstrated the value of early engagement of key stakeholders in such community-based telehealth projects to facilitate addressing health disparities that impact access to care due to cost, limitations, and education. The authors also asserted the value of such projects in solving for the “digital divide” by bringing telehealth to underserved populations.4

For any of us that may have doubts about the value of telehealth versus the face-to-face visits and care management of chronic conditions, studies pointed us in a direction of possibilities. The first was in rural Montana on diabetics to demonstrate the feasibility of telehealth technology as a viable option to care when access is problematic. Using an interdisciplinary approach that focused on receipt of recommended preventive services, vascular risk factor control, patient satisfaction, and diabetes self-management as care outcomes’ measures, a one-year post intervention comparisons of two groups of patients yielded few differences. The researchers asserted that a team approach using telehealth may be a viable option to care delivery for underserved population in remote areas.5 Similarly, a study examined the value of telemedicine through care management and specialty (endocrinology) video-conferencing with diabetics in remote rural areas using The Reach, Education, Access, and Treatment (TREAT) model. Using HbA1c measure, findings suggested the effectiveness of the model on maintaining desired HbA1c value and the value of telemedicine in rural remote areas where specialty shortage is an additional concern.6

With a mounting volume of studies alluding to, if not demonstrating significant evidence, the value of telehealth as alternate delivery mechanism of health services, questions arise regarding the preparedness level of organizations and providers to embrace this new wave of care management. In the next section, I shall discuss telehealth in terms of nursing practices and education with highlights on the need to consider care outcomes when deciding strategies or interventions.

**TeleHealth and Nursing Practice and Education**

With the historical background that was presented and the proliferation of telehealth services in mind under the ACA, questions arise not only about the role of nursing practice and care coordination in an integrated environment but also the future of care/case management. In order to fully understand this impact, it is necessary to re-examine the myriad of nursing roles and interventions within the current health care environment and the provision of telehealth services. Following is a crosswalk of key interventions or roles from a practice perspective:
<table>
<thead>
<tr>
<th>Role/Intervention</th>
<th>Setting</th>
<th>Value of Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>With a well-known shortage of primary care physicians, advanced practice nurses are, in many instances, providing primary care. This is done in ambulatory care clinic in health centers, community clinics, long-term care placement (SNFs, Assisted Living, or LTACs).</td>
<td>In many clinics, nurses are providing disease management through diagnostics (blood draws and testing for HgA1C, Coumadin level…etc.), provision of equipment and monitors that connect patients to the medical record for continued remote monitoring of status, education on diet, exercise, and well-being, and when necessary, wound-dressing changes.</td>
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<td>Care Managers</td>
<td>Managed care case management and Hospital care coordination and discharge planning are evolving into roles and functions that involve a shift or emphasis on additional functions as priorities are shuffled.</td>
<td>Like never before, hospital case management is focused on documentation improvement, satisfaction with service with emphasis on initial and continued discharge planning where the patient-case manager encounter extends post discharge and appropriate placement. Telehealth mandates on demand availability to avoid an emergency room visit or encounter. On-time documentation is critical.</td>
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<td>Population-Health Management</td>
<td>Regardless of the setting for care, the main focus was disease management spanning the spectrum of education, levels of prevention, and treatment. This traditional model of care management was dependent on the personal encounter and the level of care setting with the assumptions that: 1) Clinicians have direct access to patient or care-giver, and 2) that adherence to the recommendations followed only to find out in future health system’s encounters that noncompliance may have been an issue for the exacerbation or readmission.</td>
<td>Many venues for care are made possible; Technology, data exchanges, long-term supportive services, and concierge medicine are creating viable options for effective and efficient care. Nurse practitioners are extending their roles into the care management realm through population care management shifting case management focus to interventions focusing on engagement of patients and care-givers, concierge services inclusive of reminders and providing access to benefits and services, and avoidance of complications reinforcing teaching, medication reconciliation, and collaboration with BH providers and pharmacists among other allied health practitioners like never before.</td>
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<td>Behavioral health (BH)</td>
<td>Care Managers were running parallel tracks; medical and behavioral health that involved different patient teaching, medications, and continued or rather fragmented care.</td>
<td>Current care coordination practices and integrated care collaboratives are forcing a merger of behavioral and medical care. When the two components of health services are joined, better health outcomes are made possible and better quality of life for patients is within reach, not to mention a tighter seal on health costs can be earned.</td>
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</table>
The behavioral component of care coordination has long been overlooked. This sentiment was echoed by Bao, Casalino, and Pincus (2013) in their discussion of three prominent models of care under the ACA to serve four patient populations with behavioral health (BH) condition focused on patients with BH and substance abuse (SA) conditions. Bao et al. (2013) explored incorporating BH into reform initiatives as they examined the patient-centered medical home (PCMH), Health Home establishment under Medicaid with designated providers, and accountable care organizations’ (ACOs) defined patient populations. The authors concluded that caring for patient populations with BH and SA conditions require demonstrated coordinated BH and medical care through knowledge sharing and integrated care coordination under the Centers for Medicare & Medicaid (CMS) innovations initiative.3

From an education perspective, it behooves us to consider potential mind-shift in our approach to care management, particularly when considering a seasoned workforce that is aging and approaching retirement, and newer generations that will carry the torch and care for potentially younger generations as well. In an opinion article, Lamb and Shea (2006) questioned nursing education programs in the era of advanced technology and telehealth in reflecting knowledge and competency in innovative thinking and skills’ level. The authors questioned the technical proficiency and the use of telehealth modalities in nursing education to prepare nurses for delivering telehealth services. Their recommendations were for education to be redesigned, adjusting for different levels of care and types of practitioners that would use such technology. The authors cited different roles and skill-sets for nurses and consequently different needs for technology use. Nurse practitioners need technology for actual care delivery versus while nurse-administrators may need that education to help them get involved in technology-use or purchase decisions. Further, nurse scientists or researchers may need technology to provide insights about care or test models of care.8

In summary, it is evident that clinical practices of the past are long headed for burial. It is incumbent upon payers, clinicians, and providers, particularly care managers, that are in the trenches of care coordination, to hone their skills in informatics and technology related to disease management and chronic care inclusive of behavioral health, be it monitoring, education, or emotional interviewing to help engage the masses and influence behavior. Care Coordination services may no longer have the traditional office space or hospital-based work but rather field work and tele-communication that show engagement, caring, and support at its highest peak thus yielding better integration of care and better care outcomes.

Stefany H. Almaden, PhD, RN, MSN, CCM, CPUM, CMCN is a Health Services Consultant/President of The Almaden Group, Inc.

References:
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Transformation: The Future of Nursing and Managed Care
Nancy Rudner Lugo, DrPH, MSN

Summary
The Institute of Medicine 2010 report, the Future of Nursing, Leading Change, Advancing Health, outlined key recommendations to create a nursing workforce prepared to improve quality of care in our diverse population and complex, transformational healthcare sector. The key recommendations have implications for improving managed care networks, services, and outcomes. AARP’s Campaign to Champion works with state Action Coalitions to implement the recommendations.

Key Points
- Nurses should practice to the full extent of their education and training; scope of practice restrictions are unnecessary, impede access, and increase costs.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. Better educated nurses are more prepared for the challenges.
- Nurses should be full partners with physicians and other health care professionals, in redesigning health care in the United States. Nurses are the largest professional group in health care, have more direct patient care, and can provide valuable perspectives in health care redesign.
- Effective workforce planning and policy-making require better data collection and an improved information infrastructure.

WITH FAST-PACED HEALTH CARE TRANSFORMATION, nursing is also evolving. Are we fully utilizing the diverse skills of nurses throughout healthcare? What changes are needed to improve health care quality by enhancing nurses’ contribution in the delivery of care? The Institute of Medicine convened an 18-person expert panel, led by former Health and Human Services Secretary Donna Shalala, to examine what nursing education and roles should be for the 21st century to meet the needs of patients of all ages in our increasingly diverse and aging population and in the complex health sector. The expert panel’s Institute of Medicine’s Report, The Future of Nursing: Leading Change, Advancing Health, released in 2010 makes four key recommendations:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy-making require better data collection and an improved information infrastructure.

To facilitate implementation of the IOM recommendations, AARP, the AARP Foundation, and the Robert Wood Johnson Foundation have had a national initiative, The Future of Nursing: Campaign for Action, since 2010. The Campaign includes state Action Coalitions in each state, incorporating the skills, vision, and reach of a broad collection of stakeholders, including health care providers, consumer advocates, policy makers as well as leaders from business, academia, and philanthropy, to implement the recommendations in their state. In some states, managed care organizations are actively involved and in at least one state, a managed care organization’s foundation provides major support. The Florida Blue Foundation, the co-lead for the Florida Action Coalition since its inception, is a great example of a corporate foundation that has not only provided financial and in-kind support and resources to the Coalition, but is also an active participant in the Coalition work. This article examines the managed care implications of each recommendation and describes the progress toward implementation of the recommendations.

The Future of Nursing Recommendations and Managed Care
Nurses should practice to the full extent of their education and training.

In spite of extensive evidence of the safety and efficacy of care by nurses and advanced practice nurses, state scope of practice regulations and organizational practices limit nursing contributions to care. Advance practice registered nurses (APRN) are nationally certified and educated in nationally accredited programs, but they are licensed by individual states in an illogical patchwork of different regulations. APRNs include certified nurse midwives, nurse anesthetists, clinical nurse specialists, and nurse practitioners. The inconsistencies among the states in how a nurse or APRN can serve patients can be problematic for national health plans. Health plans’ failure to contract with APRNs and not having APRNs bill under their own NPIs distort quality data when care is billed under the “supervising provider”. The requirements for “collaborative agreements” or “supervising physicians” can limit the ability of APRNs to serve in underserved areas of a health plan’s network or offer an innovative style of care. Economic analyses suggest removal of restrictions on APRNs could yield significant savings and reduce physician shortages, such as a 92 percent reduction in the North Carolina primary care physician shortage.
Table 1: Progress in 50 States and Washington, D.C., toward full scope of practice for APRNs

<table>
<thead>
<tr>
<th>Number of states with:</th>
<th>Nurse Practitioners</th>
<th>Nurse Midwives</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010</strong></td>
<td><strong>2013</strong></td>
<td><strong>2010</strong></td>
<td><strong>2013</strong></td>
</tr>
<tr>
<td>Full practice and full prescribing authority</td>
<td>12</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Full practice authority</td>
<td>7</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Limited practice</td>
<td>32</td>
<td>29</td>
<td>32</td>
</tr>
</tbody>
</table>

Table 1 shows the progress toward full practice for APRNs. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

As health care becomes more complex, more education is needed to strengthen the nursing profession. Further education will raise the expertise across the profession, preparing more nurses to work effectively in 21st century health care and to be more involved in shaping the health care transformation. Nursing has multiple educational pathways to the profession, including diploma, associate degree, bachelor degree and accelerated (one-year program from individuals with a non-nursing bachelors degree) programs. Incentives and support are needed for nurses to pursue higher degrees and additional training, regardless of their basic nursing education path. The lack of a seamless academic progression has been a barrier for nurses pursuing further education as well as those pursuing faculty and advanced practice roles, contributing to those shortages. Table 2 shows the progress on this recommendation.

Nurses should be full partners with physicians and other health care professionals, in redesigning health care in the United States. Nurses spend more time in patient care delivery than other professions, giving them unique perspectives on patient needs, safety, and system efficacy. Health care redesign can benefit from a diversity of views and inputs. Nurses can provide valuable insight for addressing problems such as chronic disease, a major cost driver in managed care, with health plan strategies that successfully engaged the patients. Yet nurses are vastly underrepresented on hospital and other health care boards, strategy and decision-making groups.

Effective workforce planning and policy-making require better data collection and an improved information infrastructure.

The lack of reliable data on the health care workforce and wide variability on the data collected by the states has hampered planning and decision making. With the data deficit, reliable benchmarks on nursing supply and demand are problematic, which can impact managed care staffing as well as direct care providers. The National Forum of State Nursing Workforce Centers convened a work group to identify core data that each state should collect. In 2010, only 26 states collected all 12 core items. The following year, this jumped to 40 states.11

**Conclusion**

Change is happening in the nursing profession. Progress is being made in implementation of the Future of Nursing recommendations, with significant implications for managed care. With full implementation of the IOM Future of Nursing recommendations, we can achieve better patient experience, better outcomes, and lower costs.

Nancy Rudner Lugo, DrPH, MSN is the Corporate Director, Pay for Quality for HealthSprings Inc.

**References**


Table 2: Progress toward improving education of nurses°

<table>
<thead>
<tr>
<th>Of employed registered nurses</th>
<th>2010</th>
<th>2013</th>
<th>2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent who have BSN or higher degree</td>
<td>49%</td>
<td>51%</td>
<td>80%</td>
</tr>
<tr>
<td>Number with doctorates*</td>
<td>10,020</td>
<td>12,920</td>
<td>Double 2010 number</td>
</tr>
</tbody>
</table>

* Note: 20,828 nurses were enrolled in PhD and DNP programs in 2013.