A call to action for nurse leaders: Achieve the “Fourth Aim” through innovative solutions
The health plan Chief Nursing Officer (CNO) or senior nurse executive has responsibilities across a widening portfolio of administrative, clinical and financial duties. The Patient Protection and Affordable Care Act (PPACA) has created a mandate for nurse leaders to exercise a breadth of competencies that transcend the care continuum, addressing the needs of business organization, regulators, consumers, members, and the community while simultaneously developing and nurturing a quality talent pool.

Evolving reimbursement models and value-based purchasing demand innovative approaches to care delivery transformation. These dynamic changes in the marketplace have increased demands for health plan nurse executives to provide clinical quality oversight, as well as ensuring optimal cost and resource management.

These duties are exemplified by the “Triple Aim” concept described by Dr. Donald Berwick and the Institute for Healthcare Improvement (IHI) in 2008. Legislators, regulators, accreditation entities, healthcare delivery organizations and providers have widely accepted and adopted this three-prong approach to transforming healthcare delivery in the United States. The Triple Aim initiative focuses on “improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.”

However, nurse executives must now consider a fourth dimension added to the Triple Aim. Drs. Bodenhiemer and Sinsky published a paper that comprehensively justifies the addition of a new dimension to the three in the Triple Aim – improving the work life of those who deliver care. While their paper concentrates on primary care providers, all members of the healthcare team are impacted by inefficient workflows, elevated societal expectations, inadequate resources, decreasing reimbursement experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.”  

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Background: the realities of nurse supply and capacity

There is some misconception on the supply of nurses. Between the 1980s and 1990s, nursing enrollment decreased as more higher-paid occupations opened to women. Significant nursing shortages were anticipated to occur during the upcoming decades, as an aging nursing workforce was expected to retire at the same time the demands of an increasingly older population would be exerting pressure on the healthcare industry. Yet supply remained static due to increasing patient acuity, an increase in the elderly population and more opportunities in non-hospital work environments. Also, the average RN annual wage grew nearly $20,000 between 2000 and 2010, making nursing an attractive option for entry and re-entry.

Hospitals still provide the largest employment opportunity for nurses, though this has modestly decreased over the past decade due to changes that have reduced reliance on inpatient care. Some experienced nurses have migrated to opportunities outside of clinical settings for both physical and personal reasons. For instance, between 1997 and 2007, health insurance employment for nurses saw an overall growth rate of 52%, double the rate for general health services employment. Currently, approximately 2% of registered nurses are employed in the insurance industry in a variety of roles that require strong clinical knowledge and experience.

and competing reporting demands that result in a lack of “joy and meaning” in their work. A paper published in the journal BMJ Quality & Safety highlights that the Triple Aim does not acknowledge the critical role that the workforce plays in healthcare transformation, writing, “The core of workforce engagement is the experience of joy and meaning in the work of healthcare.”

A picture of two nurses smiling at each other.
This shift was partly fueled by the increase in cost controls and care coordination. In 2008, 61% of nurses employed in the insurance industry were over 45 years old, implying a higher level of experience among those nurses. Factors that could attract seasoned professionals to this industry included wages that could be as much as 10% higher than traditional clinical settings, and traditional hours during the work week.5

The numbers of nurses have increased significantly in the decade between 2000 and 2010. This decade saw double the number of NCLEX passers and an overall growth in the RN population of almost 25%. There was also a significant uptick in the number of nurses delaying retirement compared to a decade earlier. The cohort of registered nurses over 50 now comprises slightly more than 40% of the registered nurse workforce, while the number of nurses between the ages of 56 and 70 has doubled.6 While the shortage has abated, nursing could face critical vacancy levels over the next 10 years.

This potential lack of nurses could also exacerbate issues related to job satisfaction and burnout. Studies have shown that low rates of job satisfaction among nurses can lead to a decrease in quality, patient-centered care. An increase in workload due to a lack of qualified nurses can also cause higher rates of missed important patient condition changes.7 Nurse executives must make the new Fourth Aim a priority in order to have a deep, lasting impact on patient and member care.
Influence of the ACA and the role of nursing leadership: Coordinating the 4th Aim with a changing healthcare environment

Nurse leadership has to be mindful of managing services that align to the new ACA requirements regarding the medical loss ratio, devoting between 80-85% of premium exclusively to care delivery based on the member volume serviced by the payer. Failing to meet the MLR due to higher administrative and lower clinical management costs could result in customers receiving payer rebates. Consequently, health plan care managers are in demand to provide activities focused that keep the ratio higher through member improvements, rather than just health cost reductions.

Nursing personnel in care management roles are essential for achieving the quality care outcomes and cost reduction objectives of the Fourth Aim within the construct of the ACA. Care coordinators and facilitators identify and coordinate the closure of care gaps, provide clinical documentation and advance interventions to assure that all members receive an appropriate level of care according to their needs. This strategy optimizes member outreach and access without service duplication or omission through collaboration and sharing care-related information. Such a clinical approach to
quality improvement enhances the health status of populations and fosters revenue optimization by ensuring that members are receiving the recommended levels of treatment, and then documenting the resulting impact on HCC/RAF reporting and STAR ratings.

However, a hospital’s local nursing supply may be limited to manage these additional goals. In order to meet the workforce requirements of the ACA and the Fourth Aim, nurse leaders should consider an increased use of national and global outsourced clinical services. This integration of internationally trained and US licensed resources could function as adjuncts to the domestic team and share in the management of health plan members. The additional offshore supply of qualified nurse clinicians for UM, CM and DM services can provide a seamless provision of care management services that improve member outcomes and reduce the overall cost of delivery.

Offshore staff members are frequently co-managed by the payer and service provider to ensure that performance metrics match the same standards required by the provider. Successful domestic and global hybrid models arrangements allow payers to realign their own care management staff to optimize capabilities and efficiency. Global clinical resourcing often initially targeted coding and claims processing, but their duties frequently extend to utilization and care management capabilities due to regional surpluses of professionally trained nurses. Wellness and disease management programs are also often outsourced, and generally include performance guarantees to improve outreach and engagement with members. The benefits of augmenting a payer’s care management capabilities include mirroring those processes performed by the payer’s onshore nurses while seamlessly transitioning between members and providers. Using international resources can provide qualified professionals at lower costs to contain care management costs.

The use of worldwide nurse professionals has become a viable strategy to keep rising operational costs in check, enhance member engagement and improve clinical outcomes to accomplish the Fourth Aim.
Transforming Care Management – what a nurse leader needs to know for capacity management to meet the Fourth AIM

Nursing roles and healthcare technology are becoming more related, and require capacity planning for both the qualifications and capacity strategies used by the health care organizations. This is a key area for meeting the workforce management goals of the Fourth AIM. With value-based reimbursement now paying for outcomes rather than interventions, the use of collaborative care approaches tends to minimize unnecessary and duplicative utilization of services. Nurse leaders must incorporate financial incentives which foster improved collaboration among health team members. This approach includes the need for the care managers to have the skill sets for operating in an integrated IT infrastructure to improve care coordination and collaboration across the clinical setting and the corporate enterprise.

To meet the Fourth Aim, health plan nurse professionals must engage in Population Health Management (PHM). PHM aggregates and analyzes patient data from multiple health information resources into a single, actionable patient record for use in care coordination, revenue optimization, closing care gaps and HCC/RAF analysis. Despite the advent of data warehouses and ability to share information across disparate systems, patient data has remained in informational siloes and not fully utilized by nurse care coordinators. The inability of care coordinators to access integrated data
can cause an inefficient use of personnel and duplicated services, resulting in the redundancies of high-level resources. For example, storing member diagnoses in care management or claims systems, while the corresponding member prescription information may reside in the PBM or claims system. Nurse professionals need to be hired who can use disparate data to identify member issues that would benefit from care management. Such interventions are the key to mitigating care gaps, efficient use of personnel and providing cost effective care.

A nurse executive should also employ nurses who can apply predictive modeling tools that identify and predict risk in specific populations. By incorporating pharmaceutical, claims, diagnostic and demographic data, payers can measure the morbidity burden of certain member populations. This helps care managers to recognize which members are most likely to utilize services and enables early interventions. Non-hospital services such as outpatient and ED visits may also be used to target specific high cost conditions, or identify care gaps that are used in regulatory monitoring and reporting such as HEDIS. By employing nursing strategies and care plans, the care coordinator has the ability to stratify members according to their care needs. Doing so promotes the efficient use of resources, improved outcomes and helps to balance the workloads among care managers. The difficulty is both hiring and retaining this type of workforce, as it is a high demand role with significant clinical responsibility.

The care coordinator has the ability to stratify members according to their care needs.

Nurse clinicians and care managers are also required to staff wellness, disease, and chronic care management programs oriented on achieving the member’s optimal level of wellness regardless of conditions or the presence of comorbidities. Through individually designed plans of care, the nurse determines which interventions are most
appropriate for accomplishing this goal and systematically evaluates and measures the impact of these interventions. From the payer perspective, success may be measured in reduced service utilization and improved member self-management. Outside of the commercial realm, interventions may also include socio-economic support to ensure members accomplish the desired goals.

Technology is another important component to optimizing nurse workforce capacity, as digital engagement is critical to effectively using clinical talent. The widespread use of smart phones and improved monitoring provides opportunities for improving care management. Today, 68% of US individuals have a smart phone, and 91% have a cell phone. Traditional outreach methods of outbound calling have proven to be less successful, with program enrollment rates in the 10-30% range.8

In a recent survey conducted by a major consulting firm, 72% of respondents reported satisfaction in using mobile technology to interact with their health
plan. Age is no longer a barrier to encouraging mobile use. Some members would prefer to use mobile applications to locate a network provider or simplify their refill process. These devices also enable members to report clinical metrics to care managers, who can assess the results and individualize their care plan. Smart phones are revolutionizing self-management capabilities. Bluetooth devices can integrate with smartphone apps to record and evaluate the member’s ongoing monitoring of chronic conditions such as blood pressure readings. The ability to upload these metrics directly to personal health records facilitates communication and early intervention by care managers.

However, this technology is not without its limits. More commercial plan members have both mobile and internet access than lower income members, who may have phone access alone due to the cost of internet services. This can be an important consideration when payers service the Medicaid and Medicare markets.9

It is important to reach members in the ways they want to be reached. Just because someone has texting capability doesn’t necessarily mean that it is a preferred method of contact. For instance, many care coordinators report that member portals are underutilized. Digital and particularly mobile access across multiple payer touch points is important to long term member satisfaction with member services.

Because of these new technology-driven techniques for optimizing communication with members, hiring and talent management must direct attention to gaining improved digital engagement and apply judicious insight into capacity planning. In addition, using digital technology may also enhance employee retention, as nurses could focus on using their clinical expertise to meaningfully engage with a member once contact has been established, rather than on promoting enrollment.

From a provider perspective, the use of shared platforms for member management allows providers bi-directional communication with the payer.
This includes the ability of the plan to share plans of care, alert providers to the status of member service requests, or notify the provider of member condition updates. This approach also reduces the unnecessary and mundane communication strategies that nurse care coordinators prefer to avoid, and allows greater concentration on complex, more satisfying clinical work.

**Case Management - A key area for nurse executive attention to hiring practices and attrition control**

**Recruitment/development**

The demand for case managers is growing due to the need for coordinating complex care, meeting the needs of Medicare and Medicaid and maintaining cost-effective quality outcomes. These are all critical areas to manage to achieve the Fourth Aim. Case management professionals now play an important role in PCMH and ACOs, which are financially incented to improve care coordination and integration in order to serve the needs of diverse populations.

Case management is most frequently performed by registered nurses, although a smaller cohort of licensed clinical social workers may perform case management activities in the behavioral health arena. Aligning staff to their areas of expertise ensures that they practice at the highest level of their licensure where their skillsets are utilized to maximize effectiveness in nursing. According to the Commission for Case Manager Certification, more than 40% of employers now require certification for employment. There is a need for health plans to support nurses who wish to achieve career advancement by shifting into a case management role.

The most qualified case manager candidates possess both Case Manager Certification (CCM) and bachelor’s degrees...
Achieving member outcomes and cost containment. Nurse executives should evaluate the current case management workflows within the organization to determine if the professional staff are spending time on activities that could be performed by ancillary or non-licensed staff. Administrative tasks, member engagement and enrollment are examples of some activities that could be performed to assist the licensed personal and afford them the opportunities to work more directly in member assessment and care coordination. Staff members would then effectively perform at their highest level of licensure and training.

A majority of case managers come to the profession after years of bedside nursing. Preparing for a case management role is usually done by “on the job training” with no formal education, mentoring, or clear understanding of the role and expectations. Attracting experienced healthcare professionals for case management roles can be challenging. There is a critical need to develop younger care managers before the older cohort of case managers retires. Many experienced nurses have educations and clinical skills which can be transferred to case management, but lack case management employment experience.

Health plan nurse leaders should develop training programs that incorporate these nurses into the care management organization. Experienced nurses can transfer into case management with the right training and mentorship. Allowing tenured CCMs to supervise and mentor this staff also provides recognition for their capabilities and accomplishments. Training these potential recruits in the principles and practices of case management provides an organization with an opportunity to retain seasoned professionals during the employment requirement period needed to obtain certification. Establishing expectations for staff retention in exchange for investment in certification training also helps mitigate overall attrition and turnover during the placement process.
Innovative Nurse Leaders will:

› Create care delivery models that free up resources from inefficient practices and encourage healthcare professionals to practice at the height of their licensure.

› Market the case management profession to young nurses, social workers, and other young healthcare professionals.

› Develop comprehensive educational and training programs that assist healthcare professionals in transferring their skills to the care management profession.

› Develop a learning and improvement program where tenured CCMs supervise and mentor staff, providing recognition and value for their capabilities and accomplishments.

› Develop ongoing continued education/training that keep staff abreast of industry standards and practices.

Ongoing continuing education can be provided to update and enhance clinical practice knowledge as well. By partnering with the right service provider, care management teams can receive hands-on patient care experience through clinical simulation laboratories and partnerships with community hospitals. Nurses often take advantage of these voluntary opportunities to update their clinical skills before or after their assigned shifts.
Flexible working environments also provide incentives for clinicians to make the shift to case management. Since the average case manager is now 56 years of age, many welcome the opportunity to work on a schedule free from 12 hour shifts and weekend hours. Case management is also moving into clinics and other environments that may be preferable for case managers that are interested in engaging with members face-to-face. Health plan nurse leaders should consider providing recruitment opportunities that best meet the personal needs of case managers in order to improve job satisfaction and employee retention.

An example training case
An RN experienced in care management begins working for a health plan after years of employment in tertiary care centers. Although the new job is challenging and expands the RN’s knowledge and experience, the RN feels uncertain and almost depressed. Upon reflection, the RN understands what is causing these feelings: The acute care environment continuously stimulates the senses with the sound of the medical equipment and ongoing paging. Moving to an office environment takes some adjustment.

The RN participates in a new hire program for nurses coming from an acute care setting. It provides information on the UM process, conducting medical necessity reviews, as well as the ‘ins and outs’ of CMS and commercial health plan business. Following this training program, there is ongoing support to the new RN in the adjustment to focusing on care coordination and viewing a member’s status from a different perspective. The RN is trained on topics such as the clinical details needed to evaluate the appropriateness of care, the care setting and the availability of the benefit.
In order to enhance the productivity of the case managers, health plan nurse executives should adopt technologies that can identify and stratify members based on their eligibility for case management services, as well as to perform outreach activities to engage and enroll members based on motivational assessments and potential impact. This hierarchal approach alleviates engagement activities that can tie up professional staff in unproductive engagements, allowing caseloads to be more focused on direct member care coordination and improved outcomes. By providing follow-up metrics confirming the impact of this predictive analysis, case managers could track how their work makes a difference to the members they serve. Providing clinical and financial value based on these outcomes can contribute to greater satisfaction for CMs.

Care management platforms can support case managers through sharing care plans and member alerts with providers, while also automatically processing provider-entered enrollment and service requests. These platforms can also send out messages for educating and alerting members via text on a scheduled or as-needed basis. Members who have been identified as candidates for further case management intervention could be immediately notified of opportunities to enroll in care management activities.

Taking advantage of mobile technology that effectively reaches members can increase job satisfaction for CMs. The use of smart phones or tablets to communicate with members and providers is proving increasingly effective. These new touch points include member reminders for medication adherence, sharing care plans to improve self-management, alerts on gaps in care, or integrating member-recorded metrics in care planning and assessments. Using automated outbound messaging from care management applications allows the case manager to develop rule-based triggers that identify abnormal results or other significant events. Messages can be pushed to members without the need or expense of outbound calling or mailing. This hybrid of clinical input and automated interventions leads to successful care coordination and a direct impact on case management outcomes.
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