

The Case for Integrating Healthcare Management Courses into the Curricula of Selected Healthcare Providers

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The healthcare delivery system is becoming more complex in large part due to the new organizational structures and new reimbursement schemes. As such it is becoming increasingly more evident that healthcare practitioners must be well versed in these new complexities. Little evidence exists that this knowledge is being imparted by way of the curricula of selected healthcare providers. This paper presents this case by discussing these delivery changes and suggesting way to change this lack in the fundamental education of these providers.

INTRODUCTION

With the ever increasing pressure to make our healthcare delivery system more efficient, less expensive, and provide better outcomes, both practitioners and administrators are being forced to approach their jobs differently. These focal points are not necessarily new, but they do necessitate the need to better integrate the clinical side with the managerial side.

Challenging this integration are the creation of new delivery models, new legislation, and new payment schemes. The healthcare delivery system is at a critical juncture as it transitions into the changes that will be produced by the full implementation of the Affordable Care Act (ACA) and attempts to bring the system in line with today's economic realities. Foremost among these challenges will be the expansion of the Accountable Care Organization (ACO) concept, the ever increasing movement towards bundling payment schemes, the establishment of insurance exchanges to facilitate the purchase of medical

insurance by the uninsured, the elucidation of the implications of the still vague provisions of the ACA, and the growing use of case management.

Given the complexities of these delivery and payment schemes, it is essential that both managers and providers understand them and be well versed both academically and experientially in their application.

ACCOUNTABLE CARE ORGANIZATIONS

A major assumption in the rationale for ACO's is that they will improve the quality of care while simultaneously reducing costs. They contain an inherent de-emphasis on the volume of services and focus on coordination of care to improve quality. Their organizational structure consists of a variety of delivery providers and institutions sharing responsibility for treating a group of patients. On the financial side they incorporate new performance measurements and somewhat complicated reimbursement plans. These payment plans run the gamut from total organizational performance to a global budget model somewhat akin to capitation (Vujicic & Nasseh, 2013).

Historically the concept of ACO's has existed for several years and generally referred to the responsibility of a variety of provider organizations to be accountable for cost and quality (Ronning, 2010). The passage of the Patient Protection and Accountable Care Act of 2010 (ACA) provided the framework upon which a much more formalized structure could be ascribed to the ACO concept. This structure was built upon the creation of Shared Savings Programs (SSP) within the Medicare Program by the Centers for Medicare and Medicaid Services (CMS). Essentially CMS, attempting to control costs and improve outcomes, developed the SSP to promote accountable provider organizations. To better define these organizations, the CMS classified them as ACO's. If a provider group seeks to be a participating SSP using the operating principles of an ACO they must have primary care physicians who can demonstrate that can work together to improve outcomes by using the best practices within the ACO concept. Additionally they must:

- Be accountable for quality, cost, and care of a population of Medicare beneficiaries.
- Participate for not less than three years.
- Belong to a legal structure that can receive and distribute bundles shared savings payments.
- Demonstrate that enough primary care physicians are included whose combined Medicare patient population is at least 5,000.
- Have leadership and management and clinical administrative management systems in place.
- Promote evidence – based medicine, report quality and cost measures, and coordinate care including the use of technological systems.
- Demonstrate patient-centeredness (Ronning, 2010).

Clearly, given the relative complexity of building an ACO around the conceptual framework of a SSP, both managers and providers will need a firm understanding of the costs, the operations of a SSP, the benefits of this concept, the risks, and the ability to develop and implement a strategic plan. This required skill set can either be acquired as on-the-job learning, or through a more didactic approach. Given the labor time constraints within healthcare delivery, we are recommending the latter approach.

BUNDLING PAYMENT SCHEMES

In considering how curricula are developed for healthcare professionals, there has to be a tremendous effort placed into the content, from introduction to the profession to the clinical application and practical experience that is necessary to embark upon working in healthcare.

It is often thought that management courses are an aside and have historically not been viewed as necessities, rather just good to know type of information. However, as the climate of healthcare evolves, it will be necessary for hospitals, physicians and other healthcare professionals (pharmacists, nurses and

administrators) to understand how to initiate steps for the collaboration of caring for the patients. In order to collaborate, there must be a process to establish a method of maximizing reimbursement and quality simultaneously.

According to the National Health Expenditure Projections (2011), the United States Government will soon pay more than 50% of the nation's healthcare bill through Medicare and Medicaid. With the goal of reducing cost, the Center for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (CMMI) have decided to partner with Accountable Care Organizations (ACO) and Share Services Providers (SSP) to create this system of an improved, efficient patient care experience while offsetting and sharing the cost burden between organizations and CMS/CMMI (Sultz, 2014). ACO's consist of a group of providers and suppliers of health care, health-related services, and others involved in patient care working together to coordinate care for the patients they serve (Sultz, 2014). The payment structure for ACO's combine fee-for service payments with shared savings and bonus payments linked with specific quality performance standards for which all providers within the ACO are accountable (Sultz, 2014).

It is important for healthcare professionals to understand this process that will be a major component of how payments will be received for the services being rendered. The Bundled Payments for Care Improvement Initiative (BPCI) is designed to test whether bundled payments can align incentives for hospitals, post-acute care providers, physicians, and other health care personnel to work closely together across many settings to achieve improved patient outcomes at lower cost (Sultz & Young, 2014). Lower costs, improved quality and consistency in discouraging unnecessary services, tests, medications and other costly services which are able to be substituted is what is proposed by the BPCI. Bundled Payments, also called "episode payments" is a way that CMS and CMMI have proposed to accomplish their overall efficiency goals. The bundled payments method links a number of services together for an episode of care. Based on the episode of care and the appropriate services under the bundle, healthcare providers would be provided an upfront sum to manage the care of the patient (Sultz, 2014). If the providers could manage the episode of care under the sum provided they could share the savings. As a result, providers are incentivized to coordinate care better and dis-incentivized from providing unnecessary services (Mirakhor, 2013). The facilities and the providers could be large beneficiaries if the process is done correctly. However, the bundled payment method does create complexities and will require specific skill sets that have traditionally been left to chance in the academic training of healthcare professionals or not addressed at all. Healthcare professionals of the next era must have some key skills, including the ability to collaborate beyond like professionals (working with other groups of professionals who have an overall interest in the positive outcome of the patient), an understanding of the requirements associated with making the payment process run smoothly and avoid issues that may ultimately minimize payments or require an out of pocket payout by the provider in order to accommodate for the improper balance of services provided and finally an understanding of how to manage the process of selecting the proper episodic-care or DRG that is most appropriate for bundling. Each facility will have unique considerations in every aspect of these considerations.

The objective of the BPCI is to improve the quality of Healthcare delivery for Medicare beneficiaries, while reducing the program expenditures by aligning the financial incentives for all providers (Sultz, 2014). There is great potential for the balance of expenditures to be achieved between CMS and providers, but there are some facets of the initiative that are imperative to review to be sure that the cost burden is shared. According to the American Health Associations' Committee on Research's Synthesis Report on Bundled Payments (2010), there are some key areas that must be considered by the providers. These include: 1. identifying and defining bundling inclusions (i.e. what standardized care plans should be included –ex. knee replacement, heart surgery, etc.) 2. establish a timeframe between "episodes", 3. determine payment rates, 4. identify patient criteria (do patients require a significant number of additional services beyond the bundle?). Some examples of bundled payment programs that have been initiated are: Medicare's Participating Heart Bypass Center Demo, Geisinger's ProvenCare, Medicare's Acute Care Episode Demo, PROMETHEUS Payment, Inc., Fairview Health Services and Dr. Johnson and Ingham Medical Center. Each one of these programs had to consider conditions, services, provider accountability,

a payment timeframe, administrator capabilities, how to set payments/discounts and also how to adjust payments if needed (AHA, 2010).

Each one of these standards requires a level of appreciate for the change in healthcare, balance of power in decision making and an understanding of the implications of the financial management process. BPCI will be a counterproductive method if institutions of professional learning rely on “on the job training” for new professionals. Examples of suggestions for course content could include: an introduction to reimbursement methods, bundled payments in and out, the Affordable Care Act addressing what will be the new responsibilities for future healthcare professionals and a collaborative approach to care and healthcare management.

Healthcare professionals will indeed have to manage patients as well as key components of their business, if they are going to be sustainable and reimbursed appropriately for the provided services. Therefore, they must be trained in a non-threatening, non-punitive environment, where the curriculum is enhanced to explore way to make this information relevant and specifics for each field or practice is able to have an applicable experience of learning healthcare management principles as they relate to daily practice and care of the patient. There are implications for physicians, nurses, pharmacists and administrators. The goal of training these professionals of the future should be to equip the knowledge and application of collaborating and understanding these implications of what the lack of preparation and on the job training can be. Lack of preparation in these pertinent areas of management will prove disastrous considering the vast changes to the healthcare system.

INSURANCE EXCHANGES

The Affordable Care Act (ACA) includes a provision for each state to establish an American Health Benefit Exchange (Exchange), an online marketplace to compare and shop for healthcare coverage. These Exchanges will initially serve individuals without employer-sponsored healthcare and small business employers with fewer than 100 employees. Inclusion of larger employees is expected by 2017. The goals of these Exchanges include: (1) to ensure sufficient choice providers, (2) to provide uniformity in enrollment and presentation of health benefits options, (3) to implement a quality improvement strategy and (4) to provide information on quality measures for health plan performance, which includes a rating system on quality and price and a satisfaction survey on enrollee satisfaction (Patient Protection and Affordable Care Act, 2010).

The Exchanges will also be utilized to reward quality through market-based incentives. This includes improving health outcomes through quality reporting, case management and use of the medical home model. In addition, there are incentives for preventing hospital readmissions, improving patient safety, reducing medical errors and health and wellness promotion. (Congressional Budget Office, 2012).

The Congressional Budget Office (CBO) estimates that 12 million individuals will purchase coverage through these Exchange through 2015, with 75% representing those who were previously uninsured. The enrollment through Exchanges is projected to reach over 29 million by 2021 (Congressional Budget Office, 2012). These Exchanges and additional provisions from the ACA will undoubtedly impact how physicians manage their practice and how they are reimbursed in the future.

Despite the major changes forthcoming from the ACA, a recent survey of physicians demonstrated that more than 50% were not at all familiar with how the new policies will affect their businesses. Furthermore, 70% were not familiar with how the claims process will operate. Finally, 55% expect their bad debt to increase as a result of the ACA (PR Newswire, 2013).

Exchanges will shift the role of consumers in the decision making process. Provisions under the ACA establish common rules regarding pricing and reporting and increased transparency about the quality of the provider (Patient Protection and Affordable Care Act, 2010; Orry & Eggbeer, 2012). The increased involvement of consumers in the buying process is expected to place downward pressure on price. This in conjunction with the ACA’s focus on new payment forms that incentivize health outcomes and reducing costs will shift from traditional fee-for-service payments to bundle payments, shared savings, and capitation (Orry & Eggbeer, 2012). Furthermore, quality of care will play a significant role in how

physicians negotiate with payers, which may lead to lower payments or even exclusion from the provider's network (Bendix, 2013).

The increase in the number of individuals previously uninsured is expected to place additional strain on the country's shortage of primary care physicians. This imbalance in supply and demand has led to government incentives in the form of increased reimbursement rates for primary care services. This increased demand will lead to a shift to non-physician providers, including nurse practitioners and physician assistants (Dageforde, 2013; Jacobson & Jazowski, 2011; Kocher, Emanuel, & DeParie, 2010)

The implementation of Exchanges, though its intentions to create transparency and improve access to health coverage, will impact physician practice. Increased consumer involvement and mandatory reporting will drive prices down changing the structure of payment systems. Payment systems will center on reducing costs and improving health outcomes. Therefore, financial planning should prepare for a shift from uninsured to increased utilization of exchanges, which will lead to changes in payer mix and decreases in payment rates (Orry & Eggbeer, 2012)

CASE MANAGEMENT

With the continuing evolution of new scientific medical information along with medical technology, people are living longer often with complex medical conditions which include single or comorbidity chronic diseases. In conjunction with an aging population, the concentration of healthcare expenditures in the United States (US) is escalating. Currently, US healthcare expenditures exceed 1.7 trillion dollars, which is approximately 15 % of the gross domestic product and 78% of people with single and multiple chronic conditions account for the majority of the utilization of these health care services and health care costs (Vogell et al 2009). Furthermore, a 2001 Institutes of Medicine (IOM) report, "Crossing the Quality Chasm," states that 23% of Medicaid beneficiaries have five or more chronic diseases (CCMC, 2010). Controlling costs and managing chronic diseases has become an overwhelming concern for not only private and public insurance but also for healthcare policy makers. This has led to a widespread proliferation of case management programs to help slow healthcare costs and to improve quality and delivery of healthcare services in both private and public insurance programs. In 2004, 97% of private health insurance plans have disease management programs for diabetes, asthma, arthritis, heart disease, and HIV/AIDS (Vogell et al., 2009; Fetterolf, Holt, Tucker, & Khan, 2010). State Medicaid programs have also implemented such programs to help with the efficiency and cost-effectiveness.

There are several definitions for case management, but all have similar attributes. The Commission for Case Management Certification (CCMC) (2009) defines case management as a "Collaborative process that assesses plans, implements, coordinates, monitors and evaluates the options and services required to meet the patients or clients health and human service needs. It is characterized by advocacy, communication and resource management, and promotes quality and cost-effectiveness interventions and outcomes." Central to the case management philosophy is that it is patient or client centered, whereby everyone benefits, including healthcare providers and payers, when patients or clients are navigated to the appropriate services, providers and resources in their communities to promote optimal outcomes of wellness, self-management and functional capability.

Case management is not a new concept, as it originates from the disciplines of public health nursing and social work in the early 20th century (Gritzmacher & Sowell, 2010). Thus, the majority of case managers currently in the healthcare arena are nurses or social workers with advanced degrees. There are four categories of existing case management programs. These include hospital, traditional, direct-care and gap-filling (Gritzmacher & Sowell, 2010). The emphasis for hospital case management programs include discharge planning for patients or clients who are in the hospital for a short duration due to an acute care episode, which may include finding a suitable out-patient service or facility. Discharge planning helps the hospital contain costs by reducing the length of stay for individuals whose management of their medical conditions is better suited for out-patient services. The traditional case management program uses the customary model to assess a client's health care needs in order to find appropriate services and providers that are available in the community and will help the client navigate through the intricacies of the

healthcare system. Persons with complex and or chronic diseases may require the direct-care case management model, where the case manager may be a provider for some of the needed services. The last category of the case management model is the gap-filling model. This model is similar to the traditional case management model but the case manager will also have the authority to purchase or seek out any additional healthcare services or resources that are appropriate and cost-effective for the patient or their family. The use of any of these case management programs can decrease costs and increase the quality of care and services provided, while avoiding duplication of services.

Case management model integrates some of the key components of the chronic care model, which emphasizes the coordination of a client's care around their chronic illnesses. The utilization of a case manager is also useful for navigating through the two current models of healthcare delivery systems, the patient centered medical home (PCMH) and the accountable care organizations (ACOs). The emphasis on both of these models is to breakdown the medical silos to encourage various healthcare providers to work in tandem to decrease duplication of service, to increase the quality of care to patients and to increase cost-effectiveness.

To have an effective a case management program demands an interdisciplinary approach, which includes the use of available resources and services to increase the effectiveness of evidence-based treatment modalities, quality of care and cost-effectiveness. To have such a program, it is essential that all healthcare professionals understand the case management paradigm. Current professional programs do not include case management in their curriculum. Implementing a case management course into the various healthcare professions will increase the awareness and the knowledge of the healthcare professional's role in achieving timely, necessary, and optimal healthcare services through collaboration, which will improve health outcomes especially among the chronically ill patients. In addition, this will also help with cost containment even with continued changes in the reimbursement levels by insurers.

MEDICARE PAYMENTS

Medicare in the United States is the largest public health insurance program of our time. As of 2010, Medicare covered 47 million people with an estimated spending amount of \$524 billion dollars (Nemani, 2010). With the baby boomer population aging and thereby producing increases in the cost of healthcare, coupled with an economic downturn, the sustainability of Medicare comes into question. On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) that becomes effective Jan 1, 2014. One of the things that the PPACA is slated to do is generate billions of dollars in Medicare savings and strengthen the care that our Medicare beneficiaries will receive (CMS office of the Actuary, 2010). In order to effectively execute the reforms that the PPACA is implementing over the next several years, providers will need to be educated on the management of healthcare to fully understand the various pieces that make up the PPACA. Being only clinically trained is no longer sufficient because healthcare delivery has become interwoven with intricate operational and payment schemes. In order to provide effective care and cost management to beneficiaries, clinicians will need to understand all aspects of the PPACA and particularly those that are related to Medicare. Fundamental to this understanding will be the incorporation of the new financial realities into the curricula of healthcare practitioners.

Part of the Medicare savings that our providers and clinicians will need to be aware of comes from several aspects of a delivery system overhaul via readmissions, health care acquired conditions and appropriately pricing premiums in Medicare Advantage plans. The idea is that healthcare in the United States is moving towards a value based system of care. Starting in 2013, physician payments have become closely linked to a "value-modifier" that rewards physicians who deliver better care for 5 of the most prevalent conditions – acute myocardial infarction, heart failure, certain surgical procedures, healthcare-associated infections and pneumonia (CMS office of the Actuary, 2010). In practice, physicians who provide better care to their patients will have beneficiaries who will have a lower readmission rate. Essentially the government is rewarding providers who provide quality care to clients with low cost; thereby, reducing unnecessary hospital readmissions which the PPACA states will have a substantial

projected Medicare savings. The Affordable Care Act created a hospital readmission reduction program, which is projected to reduce Medicare costs by \$8.2 billion from implementation through 2019 (CMS office of the Actuary, 2010). Readmissions account for 80% of all Medicare enrollees; thus by addressing this key population the healthcare community there will produce a significant dent into the assumed Medicare savings (CMS office of the Actuary, 2010). If providers fail to provide quality care to clients, the reduction in their Medicare payments would be 1% for 2013, 2% for 2014 and 3% for 2015 and all subsequent fiscal years; which will apply to all admissions to the hospital (Barry, Luband, & Lutz, 2010).

Not only will providers get penalized financially upon readmission of a patient, but they will also be penalized if a beneficiary incurs a hospital acquired condition (HAC's). In the past, hospital acquired conditions were reimbursed at a higher rate due to being paid as a secondary diagnosis. According to the PPACA, hospitals will face an additional 1% reduction in Medicare payments if they fall into the top 25% of the national risk-adjusted HAC rates for all hospitals in the previous year (Barry, Luband, & Lutz). This provision will result in a \$3.2 billion dollar reduction in Medicare costs over the next ten years (CMS office of the Actuary, 2010). The positive effect of this provision relates back to providing and being rewarded for quality care to all clients. As a result, a conversation among providers and clinicians will need to include some type of education that centers on the management and education of the team in providing quality care. If we have clinicians who are not accustomed to managing a team to implement the aspects of quality improvement processes, it is likely that some hospitals will struggle and be penalized financially for not meeting the new standards. Due to the lack of education that is found in various clinical healthcare programs across the country, it appears that the United States is doing a poor job at equipping our future providers and managers with the necessary skills to execute what the PPACA are imploring all healthcare providers do.

With the changes that are happening in our healthcare system due to the PPACA, it is even more important that providers at all levels have a clear understanding of how Medicare, Medicaid and commercial insurance operate. Medicare Part C, which is also known as the Medicare Advantage (MA) programs allows Medicare beneficiaries to receive benefits from private plans such as Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), high deductible plans etc. Under the MA plans, there are more services covered than under the regular Medicare Part A and B plans. Medicare Advantage plan payments from the government are paid under a bidding process. Plans bid to offer Parts A and B (Part D coverage is handled separately) coverage to their Medicare beneficiaries; the bid is offered as the bid to cover an average, or standard, beneficiary and the bid is to include any plan administrative cost and profit (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). CMS bases the Medicare payment for a private plan on the relationship between its bid and benchmark. If a plan submits a bid below than the county level benchmark value, 75% of the difference is paid between the bid and the benchmark (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). If the plan bids above the benchmark, the plan is paid the benchmark and then must pass the cost off to the enrollee by charging a premium equal to the difference between the bid and the benchmark (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010).

The problem with this is that the benchmarks amounts have resulted in higher payments to the MA plans than the Medicare Fee-for-service costs, which range from 100% to over 150% with no measured difference in outcomes (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). Thus, higher than normal payments have been being provided to MA plans, which has added to the high healthcare costs for 77% of seniors in the form of higher healthcare premiums (CMS office of the Actuary, 2010). For this reason alone, providers will need to have a thorough understanding of how healthcare insurance payments and plans operate. As a result of the changes, the provider may have an educated consumer who may refuse a battery of tests in an effort to reduce any costs that may be passed on to them. The realization of comprehensive care at a low cost will now take on a new meaning. As a result of realizing the overpayment to MA's, the PPACA will phase in benchmarks that will be set at either 95%, 100%, 107% or 115% with the higher benchmarks being reserved for those counties with the lowest Fee-For Service costs (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). Some physician practices may have to acknowledge a possible cut in the revenue stream for their offices due to the changes in MA payments.

For example, if the revenue for the physician's office received in 2009 quarter one was \$575,000 with the proposed cuts this income would be \$435,000. With the decrease in payment the physician's office may be confronted with laying off staff, readjusting the budget and/or increasing patient visits in order to make up for the deficit. Without having a firm grasp of the financial implications of the proposed changes, healthcare providers greatly jeopardize their chances for success. At the very least, clinical programs of all types need to implement education that will allow providers to have a working knowledge of healthcare management and insurance processes. Additionally, knowledge of the elements of a value-based healthcare system will allow providers to increase profitability by reaching benchmarks and putting forth quality plans in qualifying areas (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010).

The last part of Medicare that has major changes is Part D. Medicare Part D currently has an exclusionary period, commonly known as the donut hole, during which most recipients are responsible for a significant portion of their prescription drug expenses. Often times, patients will ask the nurse or physician questions about their financial responsibilities and the nurse or physician will not have an answer. While they can explain the side effects and mechanics of the drug itself, explaining if the medication is covered by their particular benefit is not in the scope of most clinicians. With educated consumerism on the rise, clinicians will now need to be aware and educated of the operations of the PPACA on prescription drug benefits. Prescription drug coverage for enrollees are provided by prescription drug plans (PDPs), which offer only prescription drug coverage or through Medicare Advantage prescription drug plans (MA-PD's) provided to beneficiaries who enroll under Part C (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). Prior to the PPACA, the Medicare Part D benefit had a deductible of \$310 and 25% coinsurance up to the initial coverage limit of \$2830 (Nemani, 2010). After beneficiaries reach this point, they end up in the so-called donut hole. The donut hole is defined as the gap in which there is no prescription drug coverage for the enrollee and they are now responsible for 100% of all prescription drug cost until they reach \$6440 (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). In order to combat this large gap, the PPACA has developed a Gap Discount program that will be implemented in phases. In phase I starting in 2010, the Health and Human Services (HHS) Secretary will provide a \$250 rebate to Part D enrollees who reach the donut hole (CMS office of the Actuary, 2010). In phase II, the manufacturers of brand name drugs must enter into agreements with the HHS Secretary to provide enrollees a 50% discount off of the negotiated price of the brand name drugs on the enrollees Part D's plan (CMS office of the Actuary, 2010). In the 2011, part III of the Gap discount phase in the PPACA required that generic drugs become covered in the donut hole by moving into an agreement with pharmaceutical companies (CMS office of the Actuary, 2010). Lastly in phase IV, which begins in 2013 and will run to 2020, the PPACA will require that some brand name drugs become covered in the gap with the enrollee co-insurance starting at 97.5% in the first year to 75% co-insurance in the last year of the phase in.

The PPACA's major focus in the Part D benefit is to enhance the coverage provided to lower-income individuals who enroll in Part D. The subsidy available for the low income population would reduce beneficiaries' out of pocket spending by paying for all or some of the Part D monthly premium and annual deductible and limiting copayment's to a minimal amount (Davis, Hahn, Morgan, Stockdale, Stone, & Tilson, 2010). Part of the education of a clinician that can help them disseminate information to low income individuals is to understand the concept of health literacy and cultural competency. Part of the issue with several curriculum developments of clinicians is that we do not include – or include a minimal amount of necessary subjects such as these into our current educational systems. While healthcare professionals will have the capability to understand the numbers presented, knowing how to relay that information to the population in which many of us work may need to be a learned task. Incorporating courses into our health care curriculum that teach nurses, pharmacist and physicians techniques to relay such complicated information will allow us to present the material in a manner that is clear and concise to our clients.

METHODOLOGY

With the existent complexities of the challenges explained in sections above, we attempted to determine the level of the integration of healthcare management courses into the curricula of four major healthcare practitioner groups. We examined the curricula of at least eight geographically disparate programs from each of the professions of medicine, dentistry, nursing, and pharmacy.

We conducted on-line searches of the curricula from randomly selected programs and identified as many healthcare management oriented courses as possible. We initially looked at any course listed that from its title might suggest that it contained some component of healthcare management. Once these courses were identified, we then sought out more expansive course descriptions of them which would provide substantiation of the content we were seeking.

RESULTS

In the basic curricula of the courses of the medical schools surveyed we found little evidence of discrete courses in healthcare management. The courses that were identified were typically courses that were introductions to either the healthcare system or environment. Additionally, some programs offered courses in healthcare policy, or healthcare economics, or business and healthcare (see Table One below). In many instances these courses were electives, and in some cases for no credit.

The investigation of dental programs yielded even scarcer results. Most of the programs investigated had only somewhat related courses in practice management. These courses were almost universally focused on career opportunities, human resources, payment arrangements, and location selection and financing a starting practice. There was little to no evidence of broader healthcare management related topics (see Table One below).

The nursing programs studied yielded similar results to the dental programs. The only significant appearance of healthcare management content was found in courses that provided an introduction to the healthcare delivery system. An occasional course in healthcare policy was identified as were some infrequent courses in trends in healthcare (see Table One below).

Pharmacy programs offered a similar pattern. In this cohort the predominant healthcare management related course was one addressing healthcare delivery or healthcare systems. Little else of direct relationship was identified (see Table One below).

TABLE ONE

Type of Program	Number of Programs	Number of HCMG Courses	Average Number of Course per Program
Medical	11	18	1.64
Dental	8	8	1
Nursing	8	16	2
Pharmacy	9	13	1.44

MOST COMMON COURSES BY PROGRAM TYPE

Medical	Free Clinical Longitudinal Outreach; Family and Community Medicine Research; Foundations of Clinical Medicine – Integration; Professionalism and the Practice of Medicine; The Practice of Medicine; Topics in Medicine; Public Health Integrative Cases; Healthcare Economics; Medical Finance; Public Policy; Population Health; and, Healthcare Policy.
Dental	Practice Administration; Practice Management; Clinical Practice Management; and, Jurisprudence/Ethics/Dental Practice.
Nursing	Transition, Leadership, and Management; Cultural Diversity in Healthcare; Introduction to Healthcare; Organization of Micro and Macro Healthcare Systems; Issues/Trends in Healthcare; and, Healthcare Systems and Policy
Pharmacy	Healthcare Systems; Pharmacy Administration; Pharmacy Care Management; Pharmacy and the U.S. Healthcare System; and Healthcare Delivery.

DISCUSSION

It is our belief that a strong case can be made for the integration of healthcare management courses into the core curricula of healthcare practitioners. As healthcare delivery more and more evolves into a business model type operation, it will be necessary for practitioners to have working knowledge of the different organizational and payment schemes. We found little evidence that this is currently being done. The only exceptions are joint programs that give a healthcare practitioner’s degree along with a MBA and these programs are not widely subscribed.

There have been an untold amount of conversations and writings centered on the Affordable Care Act. Much of this dialogue has used to term healthcare reform. And yet, the reality is the ACA is not about healthcare reform, it is about insurance and who is going to pay for what healthcare services. Clearly, the focus will continue on the business and financial aspects of healthcare delivery. Healthcare providers need to be knowledgeable of these aspects promoting their incorporation into the curricula.

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