



An Innovative Case Management Gatekeeper Model for Medicare Surgeries

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ABSTRACT

Purpose/Objectives: This article identifies the necessity of a registered nurse case manager gatekeeper in the postanesthesia care unit (PACU) at Mayo Clinic Hospital, Phoenix, AZ. The Centers for Medicare & Medicaid Services have mandated certain criteria regarding the status of same-day postprocedure surgery hospital admissions that must be adhered to in order to receive appropriate reimbursement for surgical procedures. The changes in reimbursement for surgical procedures have become more challenging. To receive optimal reimbursement for surgical procedures, Mayo Clinic Hospital initiated a case management position in the PACU to ensure compliance with the Centers for Medicare & Medicaid Services requirements. This article discusses how the case management role was developed using the Medicare inpatient-only list status determination to achieve a positive financial outcome.

Primary Practice Setting: Acute care hospitals that perform surgical procedures.

Findings and Conclusions: In 2010, Mayo Clinic Hospital sustained a loss of \$357,128 from incorrect status determinations and orders. In 2011, the PACU registered nurse case manager gatekeeper program achieved a savings of \$1 million. The estimated savings for 2012 through the end of November is approximately \$1.6 million.

Implications for Case Management: This article addresses the following:

1. The RN gatekeeper position criteria and detailed steps for beginning a PACU case management program,
2. management and organizational action plans,
3. the necessity of ongoing education of staff and physicians and the development of rapport with PACU staff, and
4. examples of case management interventions and cost savings.

Key words: *initiating a PACU RN CM role, Medicare inpatient-only list, Medicare criteria, PACU RN case manager criteria, rationale for RN CM in PACU, status determination*

Mayo Clinic Hospital, Phoenix, AZ, is an academic medical center and is one of three campuses located throughout the United States. The facility includes 268 acute care beds with 65 medical/surgical specialties. Approximately 90,000 Medicare and commercial patients receive services annually (Foster & Zehring, 2011). In 2011, there were 12,491 surgical procedures performed in 18 operating rooms (ORs), representing a 5% increase over 2010. Three new ORs were opened in January 2012. The number of daily surgeries averaged 51. In addition, 171 cardiac catheterizations, 60 interventional radiology, and 2326 gastrointestinal (GI) endoscopy patients were recovered in postanesthesia care unit (PACU; King, 2012).

The Centers for Medicare & Medicaid Services (CMS) instituted specific reimbursement requirements regarding same-day surgical procedures for the CMS population (National Heritage Insurance Corporation, 2011). A list of inpatient-only

procedures is compiled by the CMS annually from the Current Procedural Terminology (CPT) codes mandated by the American Medical Association. The Medicare Strategy Unit (2012) at Mayo Clinic Hospital updates this list yearly and care management conforms to these regulations. Any procedure on the inpatient-only list must be assigned as inpatient for CMS reimbursement; any procedure that does not appear on this list is required by the CMS to have an obligatory 4- to 6-hr recovery time, called extended recovery, in PACU, formerly known as the recovery room. Extended recovery must be applied to all same-day postprocedure admissions prior to a

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written physician status determination order of either observation or inpatient. Mayo Clinic Hospital experienced difficulty meeting this CMS revenue requirement; thus, completion of the 4- to 6-hr recovery time frame before making a status determination resulted in loss of revenue.

The Medicare inpatient-only list stipulates the specific procedures that must have inpatient status. To comply with this directive, a surgical procedure on the inpatient-only list must have a written physician preprocedure inpatient order before the patient being taken to the OR. When the patient arrives in the PACU following the procedure, the case is reviewed to verify that the planned procedure was done. If so, the physician must write a postprocedure inpatient admit order. However, if the planned surgical procedure was not done or was not on the inpatient-only list, an order for extended recovery must be written. The patient will be followed for the 4- to 6-hr time frame by the PACU registered nurse case manager (RN CM) before making a status determination of observation, inpatient, or leaving the patient in extended recovery. Failure to thoroughly comply with this mandate has unequivocally affected the CMS reimbursement payments to health care institutions.

LITERATURE REVIEW

The literature search did not reveal many articles that specifically related to an RN CM gatekeeper role for Medicare same-day admission procedures that are impacted by the CMS mandate in PACU. References were found that explained the mandate and rationale in general terms. However, much confusion regarding this initiative remains.

According to Meyerson (2011), there is a delicate balance between the “revenue cycle and case management” that may benefit acute care facilities. A surgical procedure on the Medicare inpatient-only list that is not ordered in the correct status prior to the commencement of surgery will not be able to be billed to Medicare and represents a revenue loss to

the hospital. Because of processes that hospitals have designed, many of these incorrect statuses are caught by an astute PACU RN CM. In summary, placing an RN CM in the PACU to monitor same-day surgical and diagnostic admissions to the hospital can be a positive addition.

Case managers in the hospital setting must be cognizant of Medicare criteria vis-à-vis observation admissions. Hale (2011) notes that observation status in postsurgical patients is acceptable only if there is a complication following the scheduled procedure. Physician orders preprocedure should state “outpatient in a bed” or “extended recovery.” Routine postoperative care and monitoring are not appropriately observation status just because the admission may exceed 23 hr. Determination of observation or inpatient status should be based on assessment and treatment.

Physician documentation is the basis for determining the status for hospital admissions. The article “Reducing Admission Denials: Case Managers Are Key” by McCabe (n.d.) advocates that case managers who develop excellent communication skills and rapport with physicians are invaluable assets when levels of care decisions are being discussed. Establishing the correct status in the beginning can prevent coding errors and denial issues when billing for hospital and physician services.

The Medicare Recovery Audit Program (RAP), formerly Recovery Audit Contractor (RAC), was established in 2005 for the purpose of identifying hospital overpayments and underpayments. The audits have revealed a large number of improper Medicare payments and reimbursements. Hospitals are best served by addressing these issues and are developing processes and performing self-audits to prevent RAP penalties and/or denials. An important asset has been the addition of CMs in the PACU. Patients who are requiring surgical and diagnostic procedures are monitored closely for correct status, thus ensuring appropriate reimbursement (Cirillo, 2012).

According to the Medicare RAC Program (2008), between March 2005 and March 2008, \$1 billion was identified by RAC as improper Medicare payments made to hospitals and providers in six states across the United States with high Medicare volumes; 96% (\$992.7 million) resulted in overpayments and 4% (\$37.8 million) in underpayments. The net result collected and returned to the Medicare Trust Funds from hospitals was \$693 million. The program has been successful in recouping Medicare hospital overpayments that have exceeded costs; thus, RAP is here to stay. Commercial payers have noted RAP effectiveness in postpayment reviews and have started to follow RAP-like reviews for collection of overpayments.

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A teleconference sponsored by the National Heritage Insurance Corporation, a Medicare Administrative Contractor for Jurisdiction 14 A/B MAC (2011), entertained numerous questions from participants concerning the status of same-day surgical hospital admissions. Frequently asked questions concerned the Medicare inpatient-only list. The answers were evidence of the confusion that still exists regarding CMS regulations pertaining to inpatient, extended recovery, or observation status.

THE RATIONALE FOR RN CASE MANAGEMENT IN THE PACU

Prior to 2012, Foster and Zehring discovered numerous CMS-missed reimbursement opportunities at Mayo Clinic Hospital involving procedures that were on the Medicare inpatient-only list. Providers lacked an understanding of the importance of the Medicare inpatient-only procedures and processes. In 2009, Mayo Clinic Hospital experienced a revenue loss that totaled \$357,123; \$80,000 came from RAP denials by the CMS, and \$277,128 came from commercial insurances that had chosen to follow Medicare guidelines. To rectify the issue, the Care Management Department made the decision to own and remedy the issue.

The first step was the formation of a process improvement team. The team was composed of members from various hospital entities whose input would be valuable to the initiation of the PACU CM program. The care management department director, manager, physician advisor, and RN CM were critical to the organization of the initiative. Other essential members of the process improvement team included the assistance of the patient financial services director and the Medicare Strategy Unit representative. Several ad hoc members such as directors, managers, and supervisors of cardiac catheterization, interventional radiology, GI endoscopy, information technology, and nursing informatics were important assets to the development of the program. In hindsight, the inclusion of a surgical coder would have resulted in a positive benefit, but unfortunately it was overlooked at the onset of the program.

All of the selected individuals represented departments within the hospital that directly impacted patient care or finances. The group was charged with the objective of developing an action plan and goals that would comply with the CMS mandate regarding same-day surgical procedures for the Medicare population. Nursing informatics redesigned the physician order set in the electronic medical record (EMR) to include the option to order extended recovery.

The next step was to add a new position to the care management team, a designated RN CM that served the PACU area exclusively. The expectation was for the RN CM to function in the role as a gatekeeper for same-day surgical procedures done at the Mayo Clinic Hospital. A gatekeeper can be defined in terms of (a) monitoring patient movement or flow through various entry gates of admission, (b) assessing the appropriateness of patient movement through the acute care continuum, (c) ensuring that the appropriate level of care and service has been assigned to each patient, (d) monitoring the EMR for correct admission and subset orders, and (e) identifying barriers to care such as insurance requirements, language needs, access to needed discharge resources, and tools that help facilitate a safe discharge for the patient. Gates of admission to the PACU can include same-day admits to the preoperative areas for the OR, cardiac catheterization, laboratory, interventional radiology, and GI endoscopy suites, admits directly from the Mayo Clinic Hospital, the emergency department, direct admits from a hospital unit, or transfers from another health care institution. As a gatekeeper, the RN CM assigned to PACU would monitor the flow of patients into and out of this area, ensuring that the appropriate level of care and service has been assigned to each patient on the basis of insurance, procedure done, and intensity of service required postprocedure. Other responsibilities include monitoring that correct physician orders have been entered into the patient's EMR and assessing any needs the patient might have for discharge. If the patient does admit to the hospital postprocedure, the information collected by the RN CM in PACU is

passed on to the inpatient CM assigned to follow the patient for the duration of his or her hospital stay.

In general, the PACU area tends to be a fast-moving environment that experiences high daily patient volumes flowing in and out within a very short time. The role of the RN CM for this unique area requires an individual who is flexible, adaptable, and able to perform multitasks quickly and successfully. The RN CM gatekeeper needs to become familiar with the OR flow, procedures, staff, and the physician providers. In order for the process to be successful, the RN CM has been equipped with a computer in an area of PACU where patient charts can be viewed and communication with PACU staff and attending physicians can take place. Building staff rapport is essential. Correct status can be achieved by monitoring the Medicare inpatient-only list and following up with the surgical procedures done once the patient arrives in PACU postoperatively.

The PACU CM gatekeeper role began with one RN CM who monitored the OR procedures on a Monday-to-Friday basis from 8:00 a.m. to 5:00 p.m. starting in February 2010. However, it quickly became apparent that many procedures were being completed after 5:00 p.m. each day, and patient admissions and/or discharges were occurring late into the evening, thus necessitating the addition of another RN CM to cover PACU from 5:00 to 10:00 p.m. Also in 2010, the diagnostic procedure areas of interventional radiology, cardiac catheterization, and GI endoscopy required closer CMS Medicare reimbursement monitoring. These areas served as gateways by which Medicare patients entered the hospital and were frequently admitted the same day postprocedure to extended recovery or observation. Thus, another RN CM with similar credentials was added to the team in early January 2011 to ensure that Mayo Clinic Hospital captured all CMS reimbursements from these critical outlying areas.

GETTING EVERYONE ON THE SAME PAGE

Care management at Mayo Clinic Hospital has taken a leading role in the continuous education of surgical staff, physicians, residents, physician assistants, and RNs regarding status determination of the Medicare population. As mentioned previously, the coordination of numerous hospital departments has been critical to the development and improvement of the status determination process. Information technology and nursing informatics are key resources for facilitating physician computer order entry. When an attending physician enters an incorrect status order on a Medicare patient, the RN CM uses this learning opportunity to explain the reason for the order status change.

A case example: A Medicare patient is scheduled for a total knee arthroplasty that has a CPT code of 27447. The provider may or may not be aware that this procedural code is on the Medicare inpatient-only list. When entering the preprocedure order, the provider correctly orders inpatient status. Preprocedure and postprocedure orders must be entered on all Medicare inpatient-only procedures. The critical order is the admission status postprocedure. One can determine whether status orders are correct by looking at the operative documentation that specifies the exact surgical procedure done. In this instance, the anticipated surgical procedure of a total knee arthroplasty was done; however, the provider entered an extended recovery order. This education opportunity allows the PACU RN CM to communicate and clarify the CMS mandate regarding this procedure, the reason for the order to be corrected to inpatient for reimbursement purposes, and how a correct order positively impacts Mayo Clinic Hospital. Often permission is obtained from the provider for the RN CM to enter the correct status change order clarification. This correct status order ensures appropriate reimbursement and is known as a “Medicare Save,” thus saving the facility from a potential RAP denial. A record is kept of these savings and totaled at the end of the year to demonstrate why the RN CM gatekeeper position in PACU is so vital. Overall, very positive results have been obtained regarding the teaching and learning on the part of both the medical/surgical staff and CM. The determination of status of Medicare patients in the PACU setting pre- and postprocedure is a vital role and responsibility of the RN CM gatekeeper. Several important duties must be performed both the day before the scheduled surgery and the day of surgery (see Figure 1).

The day prior to surgery: The PACU RN CM reviews the surgical schedule, checks the CPT codes on file from the precertification department, verifies that the scheduled surgery matches the CPT code given to the precertification department by the provider, and checks the EMR for preoperative/preprocedure orders

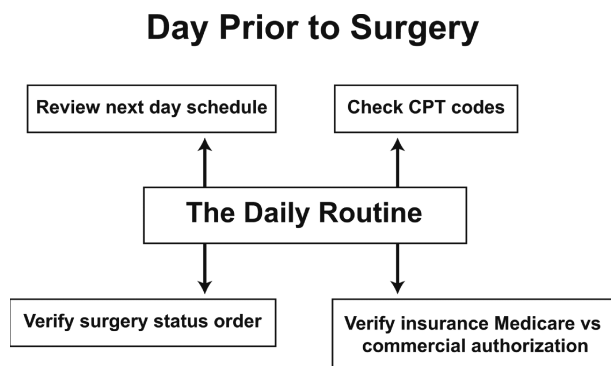


FIGURE 1
The daily routine (Diagram 1).

Day of Surgery

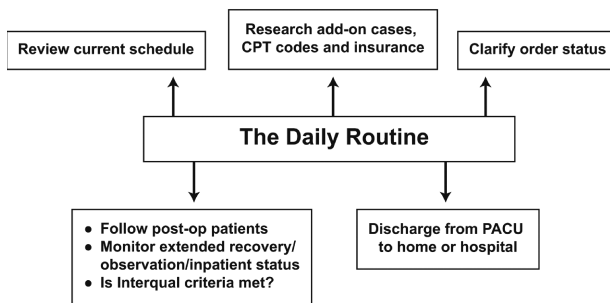


FIGURE 2
The daily routine (Diagram II).

that match CPT codes for either inpatient or outpatient procedures (see Figure 2).

The day of surgery. The PACU CM reviews the surgical schedule, including add-on cases, and verifies that

all the Medicare inpatient surgeries have preoperative/preprocedure inpatient orders initiated before the patient is taken to surgery. Postoperatively, the CM will follow the patient for correct orders, ensuring that status criteria have been met, and the patient either transfers to the floor or discharges out of the hospital from the PACU area (see Figure 3).

Status is critical: Was the surgical procedure performed on the Medicare inpatient-only list? If the CPT code is on the Medicare inpatient-only list, the RN CM will ensure that the surgeon has a postoperative inpatient admit order. If the CPT codes to an outpatient procedure, the CM will search for a preoperative/preprocedure order for plans to either discharge home from PACU or admit to extended recovery.

Once the surgery is completed and the patient is taken to PACU, the RN CM ensures that the postoperative orders match preoperative/preprocedure orders. If the attending physician enters a postoperative order

Medicare Same Day Surgical Admits: Status is Critical

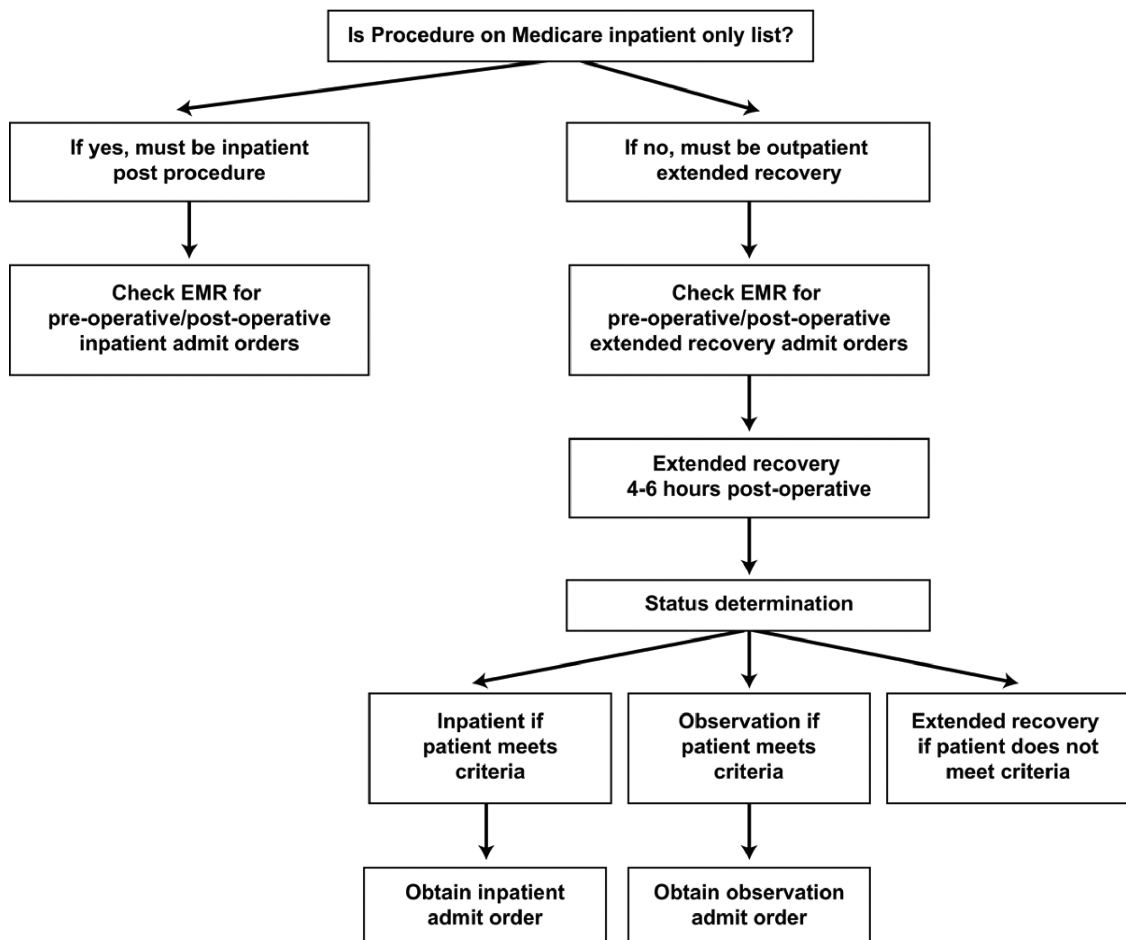


FIGURE 3
The daily routine (Diagram III).

for extended recovery, the RN CM will monitor the patient for 4- to 6-hr postprocedure. The monitoring includes following the patient's vital signs, treatments, or medications used for pain management, nausea, hyper-/hypotension, arrhythmias, blood sugars, O₂ needs, and so forth. At the end of this time frame, a review with the attending physician and the PACU RN is done to determine whether a 23-hr observation or inpatient status is appropriate for the patient. The correct admit order is entered into the patient's chart and they are moved out of PACU to a hospital bed on the floor.

The following is an example of a procedure and how correct status is determined. A Medicare patient is scheduled for an Artificial Genitourinary Sphincter. This procedure is *not* on the Medicare inpatient-only list and is an outpatient procedure.

- RN CM reviews the initial preoperative order intent—Extended Recovery.
- The Artificial Genitourinary Sphincter surgery is performed.
- RN CM confirms the procedure by checking the Intraoperative documentation, the OR Progress Note, or the documented operative report.
- The postoperative order for extended recovery is entered.
- RN CM monitors the time that the patient arrives in PACU for the next 4 to 6 hr.
- A final status of extended recovery, observation, or inpatient is determined.

If the PACU RN CM determines an incorrect status and, for example, the patient is immediately placed in an inpatient admit status postoperative and discharges in this status, the failure to comply with CMS guidelines will directly affect reimbursement payments; the net loss of revenue for this procedure would be \$12,302.

A second example of status determination might be a Medicare patient who is scheduled for a radical retropubic prostatectomy. This procedure is on the Medicare inpatient-only list (CPT 55866).

- The RN CM reviews the initial preoperative/preprocedure order. Inpatient admit status is intended postprocedure.
- The radical retropubic prostatectomy is performed.
- The RN CM confirms the procedure by checking the Intraoperative documentation, the OR Progress Note, or the documented operative report.
- The postoperative order for inpatient status is entered and initiated.
- The correct status of the inpatient is determined and a hospital bed is ordered. The patient is moved out of PACU to the floor and the assigned RN CM on the floor will continue to follow the patient until he or she is discharged from the hospital.

If the PACU RN CM documents an incorrect status and the patient undergoing radical retropubic prostatectomy is immediately placed in an extended recovery status postoperation and discharges from the hospital in a status other than inpatient, failure to comply with CMS guidelines will directly affect reimbursement payments and the net loss of revenue for this procedure is \$22,612.

LESSONS LEARNED

The most important and critical aspect for this program is education of all staff. The teaching technique has been to compose a PowerPoint presentation that coincides with a specific surgical practice or service. Several areas such as care management, urology, GI endoscopy, PACU nursing staff, and OR nurses and staff have had in-services using this method. The questions following the presentations and the positive responses by the audiences are evidence of the interest in learning about placing patients in the correct status postsurgical procedure. Many more of the surgical staff are becoming knowledgeable and expressing an interest in being more in tune with the Medicare and commercial insurance status requirements. A future goal is to educate surgical attendings, residents, physician assistants, and nurse practitioners regarding the vital role that is played by entering correct status orders.

PROVING OUR WORTH

The following cases illustrate how focused attention to correct status and orders result in substantial cost savings. Reviewing and updating the Medicare inpatient-only list yearly cannot be overlooked.

Case 1. A Medicare patient was admitted to PACU following a cervical fusion with instrumentation. The CPT code for this procedure is 22845 and is on the Medicare inpatient-only list. The preprocedure order for inpatient was entered correctly; however, the neurosurgeon elected to enter a discharge order to home with self-care directly from PACU. Because of previous education, an astute PACU RN questioned the discharge order in light of the fact that a Medicare patient must be admitted to the floor in an inpatient status before being discharged home to receive appropriate reimbursement from the CMS. The neurosurgeon was contacted and educated on the reimbursement consequences regarding a discharge. The order for inpatient was reinstated, the patient was transferred to the floor, and a discharge order was written later in the day. The net savings for this case was \$13,212.

Case 2. This demonstrates the importance of the preadmit procedure order prior to the commencement

of surgery. A Medicare patient was scheduled for aortic and mitral valve replacements. The PACU CM, reviewing the day of surgery schedule, noted the lack of a preprocedure admit order. The attending was contacted and a preprocedure admit order was obtained and entered. Had this omission not been found, the entire case that includes the surgery and postoperative care in the intensive care unit and the telemetry unit of approximately \$75,000 would have been lost.

Case 3. A scheduled Medicare procedure had a CPT code that was not on the Medicare inpatient-only list. The preprocedure admit order was correctly entered as Extended Recovery; however, the surgery was more extensive than planned. The updated procedure was found on the Medicare inpatient-only list. An order was obtained for a status change to inpatient and the facility received the appropriate reimbursement.

STEPS FOR INITIATING A PACU RN CM GATEKEEPER POSITION

How to get started:

- Identify the need for an RN CM in PACU by assessing the loss of revenue due to wrong status orders postprocedure that resulted in denied payments from Medicare and commercial insurance.
- Select the right person for the RN CM PACU position.
- Form an interdepartmental team that looks at process improvement, how to comply with Medicare guidelines, improve patient care, and timely reimbursement for services rendered.
- Begin by focusing on Medicare patients who are same-day admits for surgical procedures: verify insurance, CPT codes, and the EMR for correct pre/postoperative admission orders.
- Set up a system that follows the patient from the entry gateway of the hospital, hand-offs to the floor CM, to the final discharge disposition of the patient.

CONCLUSION

The PACU RN CM gatekeeper role has evolved over a time frame of approximately 2 years. The PACU is not without challenges and stress; however, the continuous refining and streamlining of the position and workflow have led to a solid PACU RN CM team that respects and supports each other's strengths. Collaboration with the PACU staff and the care management department at Mayo Clinic Hospital has had a great deal to do with the success of this endeavor.

The initiation of the gatekeeper RN CM role in PACU resulted in a net savings of \$1 million in 2011 and an estimated savings of \$1.6 million through November 2012 (Zehring, 2012). This milestone was achieved because of close status monitoring of Medicare procedures for both surgical and diagnostic procedures. The program has received a favorable response from leadership and management at Mayo Clinic Hospital and has been expanded to include 2.5 full-time RNs.

Launching the gatekeeper initiative in PACU at Mayo Clinic Hospital has resulted in a cohesive working relationship with the surgical and PACU staff. There is a greater appreciation of CMS regulations as they relate to the Medicare population. This optimistic outcome assures Mayo Clinic Hospital continued success as a leader in quality patient care and compliance with CMS mandates regarding scheduled same-day admits of Medicare patients.

The undertaking and development of a PACU RN CM gatekeeper program may initially appear to present a facility with a daunting task. However, by taking a step-by-step approach to developing a program similar to the Mayo Clinic Hospital, an organization can expect to see the same type of successful Medicare savings results. Begin by concentrating on the surgical procedures that your organization performs on Medicare patients who are same-day admits, and work to develop confidence in handling the CMS Medicare inpatient-only list. Expanding hours and staff will be dictated by the needs of a specific facility. The outpatient procedure areas of interventional radiology, cardiac catheterization, and GI endoscopy can be added at a later date. The benefits and financial rewards of correct status of Medicare patients are well worth the intense effort that is required to initiate a PACU/CM gatekeeper program.

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