CareManagement

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INSIDE THIS ISSUE

CONTINUING EDUCATION ARTICLES:

SPECIAL SECTIONS:

DEPARTMENTS:

Gary S. Wolfe

Workforce Trauma: The Impact of Case Managers

School shootings, office violence, and threats against co-workers—these are becoming regular headlines. These events are indeed traumatic, but trauma can affect case managers even in workplaces that are not extremely dangerous. There are many types of traumatic events that occur in the workplace. They include:

- Natural disasters— hurricanes, tornadoes, earthquakes, floods, volcanoes, fires
- Human-caused incidents— explosions, fires, violence due to firearms or other weapons, rape, threats, robbery, assaults, domestic violence, stalking
- Deaths (including homicide/suicide—on the job, away from the job, work-related, accidental, disease-caused, violent
- Downsizing/layoffs—mergers, buyouts (large or small, by division or across the board)
- Bullying

We live in emotionally traumatic times. In a turbulent world, case managers must be prepared to deal with workforce trauma. Unfortunately, no workplace can consider itself immune to traumatic events. An individual can be the only one who is directly affected by a traumatic event or the traumatic event can be large scale and affect many people. Untreated workplace trauma can lead to decreased productivity, increased sickness and absenteeism, poor morale, and staff resignations. A prompt response can relieve the stress resulting from trauma.

Why is it important for you to consider workforce trauma? Your short-term and long-term success may depend on your response to a traumatic event. The case manager may want to identify and assess the risk of potential traumatic events and prepare a response plan. The risk can be for specific natural disasters or may be particular to the nature of the work and organizational culture or the geographical location. The case manager must prepare a response plan to prevent or at least lower the risk of workplace trauma and to plan for unavoidable or unpredictable events.

What can case managers do to effectively deal with workforce trauma?

1. Have a plan in place before any traumatic event. Talk with your employer and fellow case managers. Be prepared.
2. Once an event happens:
   a. Communicate about the event. Your mind needs to process what happened so that it can resolve your personal feelings. Talk with your co-workers, manager, employee assistance program (EAP) counselor, family members, and friends. Bottling up your feelings will inevitable cause them to appear later in unpredictable ways. You may want to get the phone numbers of some of your co-workers so that you can support each other.
   b. Ask for nurturing when at home. Sometimes friends and family may not understand the feelings you experience following a traumatic event. Ask your loved ones to help you relax by being supportive and understanding.
   c. Use natural methods to relax. Taking a warm bath, having a massage, or playing your favorite music are much better ways to relax after a traumatic event than drinking alcohol. Pamper yourself after a difficult experience. Exercising is also a great way to deal with stress.

continues on page 33

CareManagement

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Getting Certified, Staying Certified, and Developing Others

By Sandra Zawalski, MSN, CRRN, CCM, ABDA, MSCC, *Commission for Case Manager Certification*

Even as the practice of case management continues to grow and attract professionals from multiple health and human services disciplines—including nurses, social workers, counselors, and others—the question is still being asked: Why should practitioners become certified and stay certified? The Commission for Case Manager Certification (CCMC) took on this question at its recent 2018 New World Symposium, at which I was proud to serve as taskforce chair.

The facts and figures make a compelling case. The percentage of employers requiring board certification grew to 40.2% in 2014 (based on the most recent Role and Function Study), an increase from 35% in 2004. Over that same 10-year period, the percentage of employers offering additional compensation for board certification rose to 29.9% from 20%. In addition, more recent field research found that 62% of employers of Certified Case Managers (CCMs) reimburse for the examination and 50% pay for it.

These numbers are even more impressive when we consider the history of case management. In the practice's earliest days in the 1980s, the title "case manager" was largely unknown and there were no uniform standards to define the practice of case management. The CCMC and its CCM board certification stepped into this void, offering its first certification examination 26 years ago. Since then, more than 60,000 case managers have been board certified, and there are currently more than 44,000 CCMs in practice today.

The percentage of employers requiring board certification grew to 40.2% in 2014, an increase from 35% in 2004. Over that same 10-year period, the percentage of employers offering additional compensation for board certification rose to 29.9% from 20%.

While CCMC continues to spread the word among employers on the value of certification, not every case management professional has the advantage of financial support or other incentives from their employer for getting and staying certified. For these professionals, certification involves both hard work and some sacrifice. Having made the choice to becoming board certified (as well as to pursue a master's degree later in my career and other credentials), I can attest to the intrinsic value of having CCM certification.

Certification serves as a guide in pursuit of the Triple Aim, with its goals of improving the experience of care, improving the health of the population, and reducing the per-capita cost of care. Board certification also supports the Quadruple Aim, which includes the additional goal of engaging in self-care to avoid burnout and improve work/life balance.

But there is another reason for being board certified, which took me by surprise when I first encountered it: through the achievement of certification, and with my many years of practice in the field, I came to be regarded as a "subject matter expert." As case managers in every discipline and practice setting discover, becoming certified and pursuing the continuing education requirements for maintaining certification elevate one's practice. This includes mentoring and teaching others to help develop the next generation of case management professionals, which is the center of my professional life.

Board certification does far more than add an acronym after our names. It reminds us of how we are guided by certification and the standards of practice, including a Code of Professional Conduct and multiple resources available through CCMC (Issue Briefs, the Case Management Body of Knowledge, and more). This support is essential on those days when we face tough questions as we advocate

continues on page 33

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Responsibilities Inherent in Case Management

Jose Alejandro, PhD, RN-BC, MBA, CCM, FACHE, FAAN

I recently transitioned into a new leadership position as the director of care management at University of California Irvine Health, a trauma and magnet-designated academic medical center in Orange County, California. Transitioning into the Case Management Society of America presidency while assuming a new role can be overwhelming, but I am truly blessed and thankful to have the support of my family, employer, colleagues, and friends. Change is inherent in all that we do in health care, so why not jump in with both feet?

As case management professionals, we have a responsibility to engage stakeholders in transforming a health care system that continues to have health care access, care transition, and quality opportunities. Payers, regulators, and consumers want value within the US care delivery system. Case management truly is the link between care providers, and we are consistently challenged to develop and maintain productive relationships with peers throughout the continuum of care. Case management professionals should continue to seek opportunities to build their professional network of colleagues. We are in this together, and we all need a helping hand (and a shoulder to cry on) from time to time.

As a profession, case management is responsible for adopting evidence-based practices and establishing and developing competencies that support our practice within a transforming health care system. We need to rigorously scan our environment for new opportunities to collaborate with multiple disciplines to leverage our ability to improve our practice. When we put our clients, patients, and residents first, we have the ability to connect purpose to passion. For many, this connection is what allows us to become more resilient.

Case management truly is the link between care providers, and we are consistently challenged to develop and maintain productive relationships with peers throughout the continuum of care.

As change agents, we need to be willing to take informed risks. We will not transform our practice if we do not test new ideas. System change is a process, and the improvement process requires us to be willing to fail, readjust, and move through another cycle of change. Acknowledging that failure will happen is a healthy way of improving our emotional intelligence. It is far better to venture forward than to sit back and allow others to make change for us.

As mentors, we need to clearly explain the "why." When stakeholders understand why we need to change, they become more engaged in the journey. Providing a vision and rationale for change reduces resistance, anxiety, and fear of change. "Transparency" is the in-vogue phrase that is being heard nationwide. In my mind, what we are really trying to convey is the importance of effectively "communicating" our vision and current performance. In my experience, high performers respect leaders who provide honest feedback on how they can improve.

As case managers, we understand how precious time is. We need to develop strategies that help us work smarter instead of harder. How can we better leverage our existing relationships and resources to meet organizational and individual needs? What skills do we need to further develop in order to become more efficient and effective? How can we embrace population health while still providing individualized care and service?

As a professional association, we have a responsibility to our membership to listen. We value your thoughts and feedback with regard to how we can assist you as a professional. We recognize that there are many competing interests, but we truly want to be your trusted resource as a professional case manager. Your input helps us improve continually in order to better meet your needs and advocate for our profession at the national and regional levels.

As individuals, we need to celebrate the contributions that we make every day to improve our care delivery system. We truly make a difference in the lives of many individuals and their families. Taking the time to thank those around us for their contributions is an important way of demonstrating how much we value their help and assistance. Take time to celebrate! It will recharge your perspective and engagement in a transforming health care environment. CM

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Eye Opening Results of Survey on Patient Privacy

By Elizabeth Hogue, Esq.

In a report entitled "Losing the Cyber Culture War in Healthcare," Accenture summarized the results of a survey of 912 provider and payer organizations across the United States. The results are startling.

Approximately 20% of survey respondents said, for example, that they would sell confidential information about patients to unauthorized parties for as little as $500! Specifically, employees said that they are willing to sell login credentials, install tracking software, and download data to portable drives for unauthorized parties for as little as $500 to $1,000.

In addition, survey results include:

Close to 24% of participants in the survey said that they knew of someone in their organizations who sold credentials or access to unauthorized outsiders.

Respondents from 21% of provider organizations surveyed said they would sell confidential data. In contrast, only 12% of employees of payer organizations said they would do so.

On the other hand, almost all participants in the survey (99%) said they felt responsible for data security.

Even though 97% of participants said they understood their organizations' data security and privacy standards, 21% keep their username and password written down next to their computers.

Approximately 1 in 6 employees were unaware of cybersecurity training conducted at their organizations.

A third of all employees who received training did so only once.

Of participants who received security training, 17% said that they continued to write down their usernames and passwords and 19% said they were willing to sell confidential data.

In an eye opening survey on patient privacy, approximately 20% of survey respondents said that they would sell confidential information about patients to unauthorized parties for as little as $500.

Surprisingly, the above numbers increase for employees who receive frequent training. Of employees who receive training on a quarterly basis, for example, 24% said they wrote down their usernames and passwords and 28% said they were willing to compromise confidential data if the price was right.

In light of the above, it is likely that providers should spend more time educating and monitoring their own employees. While a great deal of attention has been paid to hackers, it seems possible that they aren't hackers at all but have help from the inside.

Based upon this study, it's also possible that too much effort by employees is focused erroneously on issues like whether information should be released to patients' family members, for example, as opposed to the basics of securing protected health information. Anecdotally, patients' families are repeatedly denied access even though HIPAA (Health Insurance Portability and Accountability Act) was never intended to and does not prohibit health care providers from sharing information with family members and others involved in a patient's care. The HIPAA Privacy Rule allows covered entities to disclose protected health information to family members, other relatives, close personal friends, or other individuals identified by patients. Information may be shared that is directly relevant to such a person's involvement in a patient's care or payment related to a patient's care.

The Office for Civil Rights, the primary enforcer of HIPAA requirements, reaffirmed the appropriateness of such disclosures in a publication entitled "HIPAA and Same-Sex Marriage: Understanding Spouse, Family Member, and Marriage in the Privacy Rule" published in September 2014.

The results of this survey are an eye opener for sure and should cause providers to redirect at least some of their compliance efforts. CM

Elizabeth Hogue, Esquire, *is an attorney who represents health care providers. She has published 11 books, hundreds of articles, and has spoken at conferences all over the country.*

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Certification: The Professional "Calling Card"

By Ed Quick, MA, MBA, CDMS, CRC

Very early in my career, while working as an in-house rehabilitation counselor, I met a human resources executive from a large organization who told me about an employment opportunity at her firm, which greatly interested me. I applied and was one of the finalists, but in the end, I was not hired. The reason? I did not have an MBA at the time.

That feedback prompted me to attain an MBA degree, the first of many "calling cards" to make myself more marketable to large employers, which in the mid-1980s and early 1990s were changing their views on how best to address employee absences due to work-related injuries or illnesses. My experience in workers' compensation in those days was not to bring employees back on the job until they were "100%," particularly if they had physically demanding roles. Disability management and early return-to-work programs were new initiatives for managing workers' compensation cases and later expanded to nonoccupational cases. The early adopters of such programs realized the advantages: reducing the cost and duration of unplanned absences by giving employees modified duties or alternative assignments that allowed them to recuperate and heal on the job. Employers benefited from higher productivity, while employees maintained their workplace connection and earnings power.

Disability management was the cutting edge at the time, the forerunner to more-sophisticated, integrated workforce management programs that manage work-related and non-work-related absences, control the costs of those absences, improve productivity, and support employee health and wellness.

Over the years, as I've worked for several large employers, I have added to my credentials. Some of these credentials may be more familiar to my colleagues than others, but I know what they mean to me: a commitment to professionalism, ethical practice, continuing education, and evidence-based best practices. When I interact with other credentialed professionals, even if their certifications are different than mine, we establish a common ground of respect and rapport.

Across the business landscape, and particularly among larger employers, the "calling cards" of certifications such as Certified Disability Management Specialist (CDMS) and Certified Case Manager (CCM) are increasingly important. As I hire people for my team at a Fortune 100 employer, I look for professionals who have CCM, CDMS, or similar credentials after their names; these are the calling cards required to get in the door to meet with me and other professionals in my department.

The CDMS credential demonstrates the practitioner's knowledge and expertise in managing multiple benefits programs (eg, short-term disability, long-term disability, integrated disability management, and absence management) as well as paid and unpaid leaves mandated by federal legislation (ie, the Family and Medical Leave Act), state laws, and in some cases county and city regulations.

The CDMS credential, in particular, demonstrates the practitioner's knowledge and expertise in managing multiple benefits programs (eg, short-term disability, long-term disability, integrated disability management, and absence management) as well as paid and unpaid leaves mandated by federal legislation (ie, the Family and Medical Leave Act [FMLA]), state laws, and in some cases county and city regulations. In addition, these certified professionals advocate for employees with multiple health, wellness, and productivity needs and may also interact with dependents as well.

Employers today need professionals with proven expertise in managing complex benefits and leaves amid a changing legislative landscape. In addition, generous benefit plans have

continues on page 33

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2018 CARF Medical Rehabilitation Standards Manual: New Standards and Reorganization

By Christine M. MacDonell, FACRM

The new *2018 CARF Medical Rehabilitation Standards Manual* is now available at http://bookstore.carf.org/category/INT-2018_MED.html. The Manual has new standards in section 1, and section 3 has been reorganized. In this article we will discuss the new standards and the reorganization. This manual will be used in all surveys from July 1, 2018, through June 30, 2019. The new 2018 survey fees are $995, which is a nonrefundable application fee. The per day, per surveyor fee is $1,720 per day, per surveyor. The typical survey in medical rehabilitation is 2 surveyors for 2 days, so the cost is $6,880.

In 2017 we had 2 International Standards Advisory Committees revise and address our Human Resources Section of Standards and develop fundraising standards.

Let's first discuss the fundraising standards. These are in section 1, the ASPIRE to Excellence Section under Leadership 1.A. Standard 1.9 applies to organizations that directly solicit charitable financial support in connection with any program seeking accreditation. It does not apply to an organization whose fundraising is conducted by a foundation, third party, or other separate entity, or in connection with programs not seeking accreditation.

If the organization does engage with fundraising to address its accountability, it will implement written procedures that address at a minimum the following areas:

- Oversight
- Donor solicitation, communication, recognition, confidentiality
- Valuing of donations
- Use of donations in accordance with donor intent
- Documentation and record keeping
- Use of volunteers in fundraising, if applicable
- Initial and ongoing training of personnel who are engaged with the fundraising or entity

CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization

Many medical rehabilitation programs are in larger entities that might have a foundation that fundraises for the entire entity. In this example, the standard in Section 1.F.Financial Planning and Management 1.F.5 would be applied. The program would identify the type of relationship it has with the related entity, what type of financial reliance it may have, and responsibilities between the rehabilitation program and the related entity.

Throughout the years, CARF has been gathering information from providers, associations, articles, and conferences on the changes occurring in the arena of human resources. In 2017 the decision was made that across CARF International we would revise and update the human resources standards. In the 2018 Manual you will find the New Section 1.I Workforce Development and Management. The description of these standards is as follows:

CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization's ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

This new set of standards focus on the development and management from the recruitment, selection, and retention process. There are standards that address engagement from open communication and value-driven focus as well as initiatives that address recognition, compensation, and benefits. Development activities including induction are addressed. The new performance

continues on page 35

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CE 1 Care Management in the Correctional Setting

By Alexis M. Koenig, EdD, MSN, RN, CNE, CCHP

The National Commission on Correctional Health Care (NCCHC) sets the 2014 standards of care for incarcerated individuals; however, treating and managing the health of the inmate patient is as costly as it is tedious to manage. The marketing of correctional health care has become necessary to secure the rights of inmate patients to receive medical care. The complexities in managing care behind bars require well-thought-out processes to ensure that each inmate who needs health services receives timely medical care and to protect the individual rights of each inmate. This article will attempt to illustrate the need to provide quality case management services to detainees in need of health care services in order to secure an internally healthy environment.

In 2013, 1 in 110 adults were incarcerated in either prisons or local jails.[1] This number may not appear detrimental or look like it should be further analyzed until we take a closer look at the types of medical conditions that require immediate and sustainable interventions for inmates housed in correctional facilities. Care for inmate patients requires more than individualized care management. Caring for the detained inmate requires meticulous surveillance for the safety of everyone who is imprisoned or who works in the facility. As you can imagine or have seen in other care settings, it is critical to be aware of the needs of the population of the facility to manage care for the inmate population and to maintain the safety of every patient who is confined behind bars. Each jail, prison, or penitentiary can become a public health nightmare if those in charge do not take surveillance seriously. For example, a missed diagnosis of tuberculosis could result in an outbreak of tuberculosis within the correctional facility. Not only is the population of the correctional facility at risk, but there could be a potential for an inmate with tuberculosis to be released from the correctional facility into the general population.

Why is case management important? How can health care workers ensure that all patients who have the right to receive health care, especially those with chronic diseases, get treatment behind bars? First, we will address why case management is important behind bars. According to the Bureau of Justice Statistics, the following facts beg us to take a closer look on how to manage inmate patient health:[2]

1. In 2011–2012, approximately 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition. This number does not reflect the fact that over half of those incarcerated reported having a chronic medical condition in the past.
2. Twenty-one percent of prisoners and 14% of all jail inmates reported ever having tuberculosis, hepatitis B or C, or other sexually transmitted diseases (excluding HIV/AIDS).
3. Prison and jail inmates were more likely to report ever having a chronic condition or infectious disease.
4. Female inmates were more likely to report ever having a chronic condition.
5. The most common chronic condition reported by prisoners (30%) and jail inmates (26%) was high blood pressure.
6. About 66% of prisoners and 40% of jail inmates reported taking prescription medication for a chronic illness.
7. More than half of prisoners and jail inmates said that they were satisfied with the health care they received while incarcerated.

Table 1 illustrates the disparities between the incarcerated and the general population.

To illustrate the enormity for a potential health care crisis of incarcerated individuals, Wagner and Rabuy[3] (2017) report: "The American criminal justice system holds more

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In 2013, 1 in 110 adults were incarcerated in either prisons or local jails.

TABLE 1 PREVALENCE OF EVER HAVING A CHRONIC CONDITION OR INFECTIOUS DISEASE AMONG STATE AND FEDERAL PRISONERS AND THE GENERAL POPULATION (STANDARDIZED), 2011–12

	STATE AND FEDERAL PRISONERS		GENERAL POPULATION*[a]	
Chronic condition/infectious disease	**Percent**	**Standard error**	**Percent**	**Standard error**
Ever had a chronic condition[b]	43.9%**	1.5%	31.0%	0.3%
–Cancer	3.5	0.4	/	:
–High blood pressure/hypertension	30.2**	1.2	18.1	0.3
–Stroke-related problems	1.8**	0.3	0.7	0.1
–Diabetes/high blood sugar	9.0**	0.8	6.5	0.2
–Heart-related problems[c]	9.8**	1.0	2.9	0.1
–Kidney-related problems	6.1	0.7	/	:
–Arthritis/rheumatism	15.0	0.9	/	:
–Asthma	14.9**	0.9	10.2	0.2
–Cirrhosis of the liver	1.8**	0.3	0.2	—
Ever had an infectious disease[d]	21.0%**	1.3%	4.8%	0.2%
–Tuberculosis	6.0**	0.6	0.5	0.1
–Hepatitis[e]	10.9**	1.0	1.1	0.1
Hepatitis B	2.7	0.4	/	:
Hepatitis C	9.8	1.0	/	:
–STDs[f]	6.0**	0.5	3.4	0.1
HIV/AIDS	13%**	0.3%	0.4%	0.1%

* Comparison group.

** Difference with comparison group is signifcant at the 95% confidence level.

— Less than 0.05%.

: Not calculated.

/ Not collected in the NSDUH.

a General population estimates were standardized to match the prison population by sex, age, race, and Hispanic origin.

b Includes only conditions measured by both the NIS and NSDUH. In the NSDUH, persons were asked if a doctor or other medical professional had ever told them that they had high blood pressure, a stroke, diabetes, heart disease, asthma, or cirrhosis of the liver.

c For state and federal prisoners, heart-related problems could include angina; arrhythmia; arteriosclerosis; heart attack; coronary, congenital, or rheumatic heart disease; heart valve damage; tachycardia; or other type of heart problem.

d Excludes HIV or AIDS due to unknown or missing data. Only those tested reported results.

e Includes hepatitis B and C for the prison population and all types of hepatitis for the general population.

f Excludes HIV or AIDS.

Source: Bureau of Justice Statistics, National Inmate Survey (NIS), 2011–12; and the Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2009–2012.

In 2011–2012, approximately 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition.

than 2.3 million people in 1,719 state prisons, 102 federal prisons, 901 juvenile correctional facilities, 3,163 local jails ....” Next, imagine a room 6 x 8 feet. An inmate housed in a cell with this approximate dimension is common. In many instances, cells have more than one inmate. Overcrowded conditions in correctional facilities are a natural concern for officials and health care workers.

The correctional population’s security management is not limited to the physical confines of the facility. Tight quarters can be troublesome for health care professionals. Imagine facilities that can hold 1,000–2,000 inmates, and remember (as noted earlier) that approximately 40% have a chronic medical condition. In fact, the admissions screening that takes place initially in a correctional setting is critical to both the individual inmate as well as the entire population. Proper and accurate screening identifies the appropriate housing needs for the inmate patient and allocates the initial provider screening track for all inmates who are incarcerated. To accomplish this tall order, facilities will need a robust informatics program designed to assign the newly admitted inmate to the correct medical services line(s) to receive prompt medical care. The intake process ensures that inmate patients will see a medical provider for assessments and follow up care. The process also ensures that sick inmates receive treatment immediately on entering the facility. Two clear-cut examples are the admission of a diabetic with high blood sugar or the detainee with untreated hypertension. Another common occurrence is the admission of an inmate who is detoxing; this inmate requires immediate intervention. The first step by the intake specialist is to determine the substance that is being abused.

How are the health care needs of inmates met behind bars? Manageable care requires identifying needs along with preventative measures. The NCCHC provides the standards to provide health care for incarcerated individuals; however, ensuring that the necessary care occurs is in the delivery of an electronic health care record system designed for correctional health care and the specific needs of the facility. Ensuring compliance is an integral part of any correctional health care delivery system. The correctional medical health care provider uses an electronic medical record (EMR) to manage inmate care and to analyze the specific health care needs of detainees within the correctional facility. The EMR replaces paper charting and processes often described as cumbersome and inefficient. Health care provider roles identified through the correctional health care programs help to ensure correctional standards can be met and ensure that inmates are scheduled according to specific health care needs. A critical example of meeting NCCHC jail standards for inmates behind bars would feature a designated list of patients who are on suicide precautions or detoxification protocols. In addition, some lists generated (or lines) may be called “sick call” or “med pass.”[4] Other lines can be generated according to the needs of the medical correctional facility and type of institution serviced. For case managers and correctional health care leaders, the specific correctional EMR systems generate reports for various services and types of care delivered within the institution. Once in receipt of these reports, facilities can modify the delivery of care.

One specific case management feature identified within a correctional medical provider’s EMR program is the identification of chronic illnesses or diseases that require specific management to meet current national medical standards. Chronic care clinics managed by the medical providers follow the 2013 Federal Bureau of Prisons Clinical Practice Guidelines[5] as well as the NCCHC Guidelines for Disease Management (2014).[6] Nursing is not exempt from chronic care management. Nursing plays a significant role in the management of chronic care conditions through patient teaching, medication administration, surveillance, symptom management, and lifestyle adjustment to include mealtime and recreation.[7] Nurses identify chronic care patients and the need for increased surveillance of symptoms through sick call lines, RN physicals, detoxification protocols, vital signs, initial assessments, and referrals from reporting security personnel concerned with an inmate’s presentation while being housed in general population. Interestingly, nursing personnel often receive reports of inmates being transferred or released from acute care settings and other correctional facilities. Nurses play an integral part in identifying an inmate’s specific case management needs.

Identifying specific case management needs involves many aspects. Case management within the correctional setting involves managing contagious diseases.[8] For example,

The complexities in managing care behind bars require well-thought-out processes to ensure that each inmate who needs health services receives timely medical care and to protect the individual rights of each inmate.

correctional facilities often have outbreaks of head lice and scabies, and thus it is important to identify and treat these cases early to avoid an outbreak. Other outbreaks that require immediate management are flu, norovirus, and, of course, tuberculosis. Identifying methicillin-resistant *Staphylococcus aureus* (MRSA) wounds requires specific vigilance in the incarcerated population. MRSA is often undetected and only suspected when the wound is visible to the naked eye. In this setting, the treatment of MRSA must be prompt and swift to prevent an outbreak among the inmate population. Inmates often hide what they suspect is MRSA because they do not want to be placed on isolation precautions. Proper surveillance of inmates with contagious diseases because of the potential outbreaks seen in tight quarters necessitates dedicated nursing case management.

Jails and prisons often receive transfers from other settings, and the facility and staff must be prepared to meet the often-complicated needs of someone released from an acute care setting into a medical housing unit within a jail. Discharge planning must occur before the inmate is admitted to ensure that the proper equipment and personnel are available to care for the inmate patient before release from the hospital. In one unique case, a patient was released from the intensive care unit requiring a bilevel positive airway pressure (BiPAP) machine and admitted to a county jail. Clearly, this is not a typical scenario for inmates who are being admitted to a correctional facility; however, this scenario is becoming more prevalent in today's complicated health care world.

Another facet of nursing care in corrections is the intentional consideration of an inmate patient's needs before discharge, whether the discharge is to another facility or into the community. This specific case management aspect requires deliberate planning. Applying sound case management skills will assist inmates upon discharge by providing the necessary resources for the patient to meet his/her individual health care needs. In the correctional setting, applying sound guiding case management principles provides safe discharge planning for both the patient and the population where the inmate patient will next reside. There is a need to manage the population health setting behind correctional walls, but there is also a need to protect the health of the general population. Therefore, qualified case managers must attend to the discharge planning needs of the incarcerated. In addition, when an inmate is transported from one facility to another or from the correctional facility to a courtroom, everyone who is exposed to the inmate must be protected.

Case management of incarcerated women who are pregnant poses a unique set of challenges in correctional nursing care. In addition to nutritional counseling, prenatal care, and patient teaching, the medical staff may need to provide addiction counseling and/or treatment. The 2017 American Congress of Obstetricians and Gynecologists (ACOG) recognized the increasing number of problems in pregnant women who were addicted to illegal drugs. In a statement regarding opioid addiction and pregnancy, ACOG noted that "Screening for substance use should be a part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman."[9] For the incarcerated, the opportunity to first identify opioid use and pregnancy is at intake. A urine drug screen and pregnancy screen at the intake screening process along with an intake history will provide the opportunity to intervene and care for opioid-addicted pregnant inmates. Meticulous case management of pregnant inmates may require methadone treatment if there is a history of opioid use. Modifying prenatal care to include additional testing for sexually transmitted diseases, ultrasounds to determine fetal growth, and additional medical services may be necessary to deliver the safest care to both the pregnant inmate and the unborn child.[9] In these cases, there is also a need for deliberate admission and discharge planning services.

continues on page 33

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CE II

Workforce Trauma: An Evolving Concern for Case Management

By Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP

Since the events in Parkland, Florida, I have engaged in many conversations with colleagues and students to debrief and debate the $64 million dollar question: What is the cause of the uptick in mass violence? There have been countless articles published on this topic, each making its own argument:

- Only one-third of patients with a mental health diagnoses receive care[1]
- Flaws in the mental health system[2]
- Lack of true mental health parity[3,4]
- Deinstitutionalization and closure of psychiatric hospitals[5,6]
- A connection (or not) between gun violence and mental illness[7]
- The role of social media[8]
- Video games triggering real-world violence[9]
- Gun violence escalation, with use of automatic and semiautomatic weapons[7,10,11]
- Gun violence as a public health problem[12]

Among the diverse perspectives on this topic, there is no industry consensus and most likely will never be. That is because there is no single cause for the increased incidence in mass violence. Despite the importance of defining root cause, a far more paramount concern has emerged. The impact of repeated mass violence episodes on the health and behavioral workforce is taking a considerable toll. This article will address various dimensions of that toll, exploring key definitions, the incidence and impact of workforce trauma, and other related concepts.

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Workforce Trauma: Definitions and Distinctions

Trauma of some type impacts every sector of the workforce, with over 1,000,000 workers absent each day due to stress-related symptoms.[13] The dynamic appears across all sectors and is referred to in several ways including but not limited to compassion fatigue, stress, vicarious trauma, and secondary traumatic stress; the definitions for each concept appears in Table 1. When any workforce becomes stressed, their ability to engage in their expected roles becomes diminished. In the health care industry, there are significant consequences that arise from the constant exposure to mass violence, which impact both the quality and safety of patient care as well as workforce retention and mental health.[14-16]

Workforce Trauma: The Latest Occupational Hazard

The interprofessional health and behavioral health workforce renders necessary treatment to victims of every mass violence event. Through their focused and intense efforts, the workforce provides crisis intervention and support to involved families and support systems. They address the vicarious emotional wounds of surrounding communities; this includes all who experience the events 24/7 across social media. Critical incident debriefing is administered to colleagues. Yet, the workforce also strives to reconcile a grand challenge in these circumstances: despite the large volume of care rendered in mass violence situations, professionals always feel an innate need to do more.

In light of the egregious nature of each mass violence attack, involved professionals on the front lines often underestimate the value of their intervention. While the smallest act can easily provide the largest impact, in the moment that act often pales in comparison with the magnitude of other factors, such as death tolls, scope of injuries, and the incident itself. Yet, the impression left by conveying empathy or demonstrating authentic concern can extend far beyond a patient's presenting need, whether physical and/or emotional.

TABLE 1 DEFINITIONS ASSOCIATED WITH WORKFORCE TRAUMA

Burnout	Exhaustion of physical or emotional strength or motivation, usually as a result of prolonged stress or frustration.[35]
Compassion Fatigue	The formal caregiver's reduced capacity or interest in being empathic; bearing the suffering of clients. It is the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced or suffered by a person.[36]
Secondary Traumatic Stress	A consequence of stress experienced when helping or wanting to help a person traumatized or suffering.[25]
Stress	A physical, chemical, or emotional factor that causes bodily or mental tension and may be a factor in disease causation.[37]
Trauma	Experiences that cause intense physical and psychological stress reactions, which could be a single event, multiple events, or a set of circumstances experienced by an individual as physically and emotionally harmful or threatening and that have long-lasting effects to the individual.[38]
Vicarious Trauma	The emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured.[39]

The health and behavioral health workforce are mandated to provide consummate attention to the public interest, if not also to assure public safety. All regulations, codes of ethics, and standards of professional practice are consistent to this end. It is imperative to attend to the integrity of each person, conveying compassion and respect for their inherent dignity and worth.[17-19] Case management's ethical priority is focused on the principles of autonomy, beneficence, fidelity, and nonmaleficence (Box 1).[18,20,21] However, attention to the pain and suffering that can accompany the human condition comes with professional caution. The energy invested during mass violence situations takes high levels of emotional reserve. An intentional effort is required to safeguard professional boundaries; they fuel the ability for any individual to self-protect, which is critical to assure career sustainability.

I'm reminded of the video that showed an interview with a physician who cared for victims of the 2016 Pulse nightclub shooting in Orlando. He vowed to keep on the sneakers he wore the evening of June 12, 2016, until the last patient from the shooting was discharged. The pictures of those bloody sneakers went viral across social media.[22] Reports of first responders who so tenderly cared for the victims and community impacted by the shooting at Sandy Hook Elementary School detailed the profound trauma experienced by all; it was forceful and invasive. I will never forget sitting with my colleagues at the nurses' station on 9/11; we worked at the hospital closest to the Pentagon that cared for most of the victims. As much as we had done on that memorable day, nobody could leave; surely there had to be more we could do for someone.

BOX 1 CCMC AND CDMS CODES OF ETHICAL BEHAVIOR

CCMC (2015)

Principle 1: Board-Certified Case Managers (CCMs) will place the public interest above their own at all times.

Principle 2: CCMs will respect the rights and inherent dignity of all of their clients.

Principle 3: CCMs will always maintain objectivity in their relationships with clients.

Principle 4: CCMs will act with integrity and fidelity with clients and others.

Principle 5: CCMs will maintain their competency at a level that ensures their clients will receive the highest quality of service.

Principle 6: CCMs will honor the integrity of the CCM designation and adhere to the requirements for its use.

Principle 7: CCMs will obey all laws and regulations.

Principle 8: CCMs will help maintain the integrity of the Code by responding to requests for public comments to review and revise the Code, thus helping ensure its consistency with current practice.

CDMS (2015)

Autonomy: To honor the right to make individual decisions.

Beneficence: To do good to others.

Nonmaleficence: To do no harm to others.

Justice: To act or treat justly or fairly.

Fidelity: To adhere to fact or detail.

Despite the importance of defining the root cause of mass violence, a far more paramount concern has emerged: the impact of repeated mass violence episodes on the health and behavioral workforce is taking a considerable toll.

Workforce Trauma Incidence and Impact

Those actively involved in caring for victims of mass violence share compelling language about the impact of the experience. A first responder who dealt with the horrific "battlefield" injuries of those individuals at Marjory Stoneman Douglas High stated:

"I know I am not the same person I was the morning I went to work, as who I am today, 2 weeks after the call. This changes you as a person."

This sentiment has been echoed by most individuals who intervened in the emergency department on that day, plus others who have worked mass violence events elsewhere. A number of professionals who rendered care during the Pulse nightclub shooting in Orlando have publicly disclosed that they have a diagnosis of post-traumatic distress disorder (PTSD), along with those from the rising number of mass casualty events around the globe.

The incidence of PTSD across professional disciplines (eg, social work, medicine, nursing) continues to evolve. Studies in both the United States and Europe have shown a range of 17% to 36% of emergency department physicians diagnosed with PTSD.[23, 24] Rates among nurses are even higher, with 67%–82% of nurses in the emergency department experiencing secondary traumatic stress.[25] Studies from the University of Georgia School of Social Work found that social workers are twice as likely to experience PTSD compared with other disciplines, with the incidence ranging from 40% to 55%.[26]

These numbers are especially concerning for the high percentage of case managers either employed in practice settings most at risk for PTSD or vicarious trauma, if not also for those who work with these patients through the course of their care. As per the last Role and Function Study conducted by the Commission for Case Management Certification,[27] these numbers include:

- 28.94%: Health insurance plans
- 22.76%: Hospitals
- 11.6%: Workers' compensation
- 7.3%: Independent care/case management
- 5.48%: Ambulatory/outpatient care
- 2%: Acute rehabilitation
- 3.64%: Veterans health or other government agencies
- 2.28%: Homecare
- 1%: Skilled care facility

The symptoms of PTSD, according to the latest edition of the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (2013), are shown in Box 2.

The occupational hazards for members of the workforce exposed to workplace trauma are abundant. Along with the increase in mass violence, other disrupters have put the health care industry on heightened alert, including workplace bullying and violence. The incidence of burnout is at an all time high across disciplines. Studies show that all health and behavioral health professionals (eg, mental health professionals, nurses, and physicians) have alarmingly high rates of PTSD symptoms.[28, 29]

- 30%–45% of social workers leave within 2 years, with turnover rates 215% higher than other professions[30]
- 43% of new nurses leave their jobs within 3 years; turnover for a bedside registered nurse resulted in the average hospital losing up to $8.1 million annually[31]
- Average national burnout rate for physicians is 54%, with costs between $500,000 and $1 million to replace 1 physician.[16]
- Up to 60% of the health care workforce overall reports burnout, with over 34% actively looking for new jobs.[14]

Workers' Compensation

In response to the dramatic rise in PTSD among professionals on the front lines of care comes concern about whether workforce trauma qualifies for workers' compensation. Advocates are actively engaged in fierce efforts to expand workers' compensation coverage in a number of states to include coverage for PTSD.[32, 33] At the time of this writing, when Florida first responders are diagnosed with PTSD on the job, they can receive medical coverage under workers' compensation. They are, however, not eligible to receive any lost wages. Recent actions will yield the passage of legislation to allow first responders who have filed claims since the Parkland shooting to be considered for workers' compensation. Those who experienced the trauma as a result of an event occurring before Parkland will not be covered.[34] In light of this potential legislation, a concern beckons: the true impact of PTSD is grossly misunderstood by those who develop and pass the laws.

Up to 60% of the health care workforce overall reports burnout, with over 34% actively looking for new jobs

BOX 2 **POST-TRAUMATIC STRESS DISORDER (APA 2013[40] AND NATIONAL CENTER FOR PTSD 2015)**

Diagnostic criteria: History of exposure to a traumatic event that meets specific stipulations and symptoms from each of 4 symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh criterion assesses functioning; and the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Criterion A: Stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: ***(one required)***

1. Direct exposure.
2. Witnessing, in person.
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (eg, first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect nonprofessional exposure through electronic media, television, movies, or pictures.

Criterion B: Intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): ***(one required)***

1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
3. Dissociative reactions (eg, flashbacks), which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: ***(one required)***

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (eg, people, places, conversations, activities, objects, or situations).

Criterion D: Negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: ***(two required)***

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (eg, "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (eg, fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pretraumatic) significant activities.
6. Feeling alienated from others (eg, detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

Criterion E: Alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: ***(two required)***

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

Criterion F: Duration

Persistence of symptoms (in Criteria B, C, D, and E) for more than 1 month.

Criterion G: Functional significance

Significant symptom-related distress or functional impairment (eg, social, occupational).

Criterion H: Exclusion

Disturbance is not due to medication, substance use, or other illness.

When any workforce becomes stressed, their ability to engage in their expected roles becomes diminished. In the health care industry, there are significant consequences that arise from the constant exposure to mass violence, which impact both the quality and safety of patient care as well as workforce retention and mental health.

Promoting Workplace Resilience

Managing workforce trauma is akin to an onion with multiple layers. However, several strategies will empower the proactive management of workforce trauma and foster greater level of workplace resilience.

1. **Process and roll only works for so long:** Many of my colleagues admit to being good in a crisis. However, doing what I fondly call "process and roll," or going immediately from one task to another is for the short term only. For the long term, this pattern yields errors and sets you up for burnout. Be mindful!
2. **Debrief PRN:** Reach out to colleagues, supervisors, and mentors who understand what you have been through. Make use of organization employee assistance programs to obtain additional counseling intervention.
3. **Accept support:** Health and behavioral health professionals are notorious for minimizing the impact of a situation, thinking it somehow indicates weakness. Truth be told, admitting you've hit a limit is a sign of strength.
   - Accept support from colleagues as well as friends and family
4. **Recharge your resilience:** Keep a current list of items that ground you readily at your disposal. In moments of high stress, you will not automatically know what those items are. You might:
   - Blast your favorite tunes through a mobile device
   - Dance like nobody's watching
   - Take reflection time over a cup of jasmine tea
   - Hit the gym
   - Head out to dinner with your best friend or partner
   - View that latest texted picture of your family member or friend.
5. **Turn off that professional switch:** I've been a health care professional for 35 years, so I know how hard this is to do. We must take our professional cape off at some point. We were human beings long before we were health and behavioral health professionals, so:
   - Make it a ritual when you leave work to do a happy dance
   - Have peers who are NOT in the business
   - Set limits for yourself
   - Just say no to peers and family members who need your professional advice

Conclusion

As long as violence is woven within the fabric of society, health and behavioral health professionals will serve on the front lines to combat it. A few closing points to promote your vigilance in addressing workforce trauma. First, along with minimizing the value of our role, we can also minimize the impact of the experience for ourselves. It is important to keep in mind that is not up to us to evaluate the significance of the interaction we have with those we care for. The value of the patient experience is often defined by the unique meaning our contact holds for the recipient of care. When the intervention occurs at a time of crisis, the worth of our presence is immeasurable. Our presence is a rare privilege at a time of raw emotion and vulnerability for others.

Finally, remember that to survive in the health and behavioral health industry takes conscious effort and keen strategy. Becoming desensitized to the human condition may seem like the easiest way to cope, though is a cautionary strategy at best. It is destined to put any professional at expanded risk of workplace trauma down the road. CE II

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continues on page 34

PharmaFacts for Case Managers

Ozempic® (semaglutide) injection, for subcutaneous use

INDICATIONS AND USAGE

Ozempic is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

- Ozempic is not recommended as a first-line therapy for patients who have inadequate glycemic control with diet and exercise because of the uncertain relevance of rodent C-cell tumor findings to humans.
- Ozempic has not been studied in patients with a history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis .
- Ozempic is not a substitute for insulin. Ozempic is not indicated for use in patients with type 1 diabetes mellitus or for the treatment of patients with diabetic ketoacidosis because it would not be effective in these settings.

DOSAGE AND ADMINISTRATION

Recommended Dosage

- Start Ozempic with a 0.25-mg subcutaneous injection once weekly for 4 weeks. The 0.25-mg dose is intended for treatment initiation and is not effective for glycemic control.
- After 4 weeks on the 0.25-mg dose, increase the dosage to 0.5 mg once weekly.
- If additional glycemic control is needed after at least 4 weeks on the 0.5-mg dose, the dosage may be increased to 1 mg once weekly. The maximum recommended dosage is 1 mg once weekly.
- Administer Ozempic once weekly, on the same day each week, at any time of the day, with or without meals.
- The day of weekly administration can be changed if necessary as long as the time between two doses is at least 2 days (>48 h).
- If a dose is missed, administer Ozempic as soon as possible within 5 days after the missed dose. If more than 5 days have passed, skip the missed dose and administer the next dose on the regularly scheduled day. In each case, patients can then resume their regular once weekly dosing schedule.

Important Administration Instructions

- Administer Ozempic subcutaneously to the abdomen, thigh, or upper arm. Instruct patients to use a different injection site each week when injecting in the same body region.
- Inspect Ozempic visually before use. It should appear clear and colorless. Do not use Ozempic if particulate matter and coloration is seen.
- When using Ozempic with insulin, instruct patients to administer as separate injections and to never mix the products. It is acceptable to inject Ozempic and insulin in the same body region but the injections should not be adjacent to each other.

DOSAGE FORMS AND STRENGTHS

Injection: 2 mg/1.5 mL (1.34 mg/mL) of semaglutide as a clear, colorless solution available in:

- Prefilled, disposable, single-patient-use pen that delivers 0.25 mg (for treatment initiation) or 0.5 mg (for maintenance treatment) per injection
- Prefilled, disposable, single-patient-use pen that delivers 1 mg (for maintenance treatment) per injection.

CONTRAINDICATIONS

Ozempic is contraindicated in patients with:

- A personal or family history of medullary thyroid carcinoma (MTC) or in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2) (see WARNINGS AND PRECAUTIONS).
- Known hypersensitivity to semaglutide or to any of the product components

WARNINGS AND PRECAUTIONS

WARNING: RISK OF THYROID C–CELL TUMORS

- In rodents, semaglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures. It is unknown whether Ozempic causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined.
- Ozempic is contraindicated in patients with a personal or family history of MTC or in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2). Counsel patients regarding the potential risk for MTC with the use of Ozempic and inform them of symptoms of thyroid tumors (eg, a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with Ozempic.

WARNINGS AND PRECAUTIONS

Risk of Thyroid C-Cell Tumors

In mice and rats, semaglutide caused a dose-dependent and treatment-duration-dependent increase in the incidence of thyroid C-cell tumors (adenomas and carcinomas) after lifetime exposure at clinically relevant plasma exposures. It is unknown whether Ozempic causes thyroid C-cell tumors, including MTC in humans as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined.

Cases of MTC in patients treated with liraglutide, another GLP-1 receptor agonist, have been reported in the postmarketing period; the data in these reports are insufficient to establish or exclude a causal relationship between MTC and GLP-1 receptor agonist use in humans.

Ozempic is contraindicated in patients with a personal or family history of MTC or in patients with MEN 2. Counsel patients regarding the potential risk for MTC with the use of Ozempic and inform them of symptoms of thyroid tumors (eg, a mass in the neck, dysphagia, dyspnea, persistent hoarseness).

Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with Ozempic. Such monitoring may increase the risk of unnecessary procedures because of the low test specificity for serum calcitonin and a high background incidence of thyroid disease. Significantly elevated serum calcitonin value may indicate MTC, and patients with MTC usually have calcitonin values >50 ng/L. If serum calcitonin is measured and found to be elevated, the patient should be further evaluated. Patients with thyroid nodules noted on physical examination or neck imaging should also be further evaluated.

Pancreatitis

In glycemic control trials, acute pancreatitis was confirmed by adjudication in 7 Ozempic-treated patients (0.3 cases per 100 patient-years) versus 3 in comparator-treated patients (0.2 cases per 100 patient-years). One case of chronic pancreatitis was confirmed in an Ozempic-treated patient. In a 2-year trial, acute pancreatitis was confirmed by adjudication in 8 Ozempic-treated patients (0.27 cases per 100 patient-years) and 10 placebo-treated patients (0.33 cases per 100 patient-years), both on a background of standard of care.

After initiation of Ozempic, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Ozempic should be discontinued and appropriate management initiated; if confirmed, Ozempic should not be restarted.

Diabetic Retinopathy Complications

In a 2-year trial involving patients with type 2 diabetes and high cardiovascular risk, more events of diabetic retinopathy complications occurred in patients treated with Ozempic (3.0%) compared with placebo (1.8%). The absolute risk increase for diabetic retinopathy complications was larger among patients with a history of diabetic retinopathy at baseline (Ozempic 8.2%, placebo 5.2%) than among patients without a known history of diabetic retinopathy (Ozempic 0.7%, placebo 0.4%).

Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy. The effect of long-term glycemic control with semaglutide on diabetic retinopathy complications has not been studied. Patients with a history of diabetic retinopathy should be monitored for progression of diabetic retinopathy.

Never Share an Ozempic Pen Between Patients

Ozempic pens must never be shared between patients, even if the needle is changed. Pen-sharing poses a risk for transmission of blood-borne pathogens.

Hypoglycemia with Concomitant Use of Insulin Secretagogues or *Insulin*

The risk of hypoglycemia is increased when Ozempic is used in combination with insulin secretagogues (eg, sulfonylureas) or insulin. Patients may require a lower dose of the secretagogue or insulin to reduce the risk of hypoglycemia in this setting.

Acute Kidney Injury

There have been postmarketing reports of acute kidney injury and worsening of chronic renal failure, which may sometimes require hemodialysis, in patients treated with GLP-1 receptor agonists. Some of these events have been reported in patients without known underlying renal disease. Most of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Monitor renal function when initiating or escalating doses of Ozempic in patients reporting severe adverse gastrointestinal reactions.

Hypersensitivity

Serious hypersensitivity reactions (eg, anaphylaxis, angioedema) have been reported with GLP-1 receptor agonists. If hypersensitivity reactions occur, discontinue use of Ozempic; treat promptly per standard of care, and monitor until signs and symptoms resolve. Do not use in patients with a previous hypersensitivity to Ozempic.

Anaphylaxis and angioedema have been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of angioedema or anaphylaxis with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to anaphylaxis with Ozempic.

Macrovascular Outcomes

There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with Ozempic.

ADVERSE REACTIONS

The following serious adverse reactions are described below or

elsewhere in the prescribing information:
- Risk of thyroid C-cell tumors
- Pancreatitis
- Diabetic retinopathy complications
- Hypoglycemia with concomitant use of insulin secretagogues or insulin
- Acute kidney injury
- Hypersensitivity

DRUG INTERACTIONS

Concomitant Use with an Insulin Secretagogue (eg, Sulfonylurea) or with Insulin

The risk of hypoglycemia is increased when Ozempic is used in combination with insulin secretagogues (eg, sulfonylureas) or insulin. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogues) or insulin.

Oral Medications

Ozempic causes a delay of gastric emptying, and thereby has the potential to impact the absorption of concomitantly administered oral medications. In clinical pharmacology trials, semaglutide did not affect the absorption of orally administered medications to any clinically relevant degree. Nonetheless, caution should be exercised when oral medications are concomitantly administered with Ozempic.

CLINICAL STUDIES

Overview of Clinical Studies

Ozempic has been studied as monotherapy and in combination with metformin, metformin and sulfonylureas, metformin and/or thiazolidinedione, and basal insulin in patients with type 2 diabetes mellitus. The efficacy of Ozempic was compared with placebo, sitagliptin, exenatide extended-release (ER), and insulin glargine. Most trials evaluated the use of Ozempic 0.5 mg and 1 mg, with the exception of the trial comparing Ozempic and exenatide ER where only the 1-mg dose was studied.

In patients with type 2 diabetes mellitus, Ozempic produced a clinically relevant reduction from baseline in HbA1c compared with placebo.

The efficacy of Ozempic was not impacted by age, gender, race, ethnicity, body mass index (BMI) at baseline, body weight (kg) at baseline, diabetes duration, and level of renal function impairment.

Monotherapy Use of Ozempic in Patients with Type 2 Diabetes Mellitus

In a 30-week double-blind trial (NCT02054897), 388 patients with type 2 diabetes mellitus inadequately controlled with diet and exercise were randomized to Ozempic 0.5 mg or Ozempic 1 mg once weekly or placebo. Patients had a mean age of 54 years and 54% were men. The mean duration of type 2 diabetes was 4.2 years, and the mean BMI was 33 kg/m2. Overall, 64% were white, 8% were black or African American, and 21% were Asian; 30% identified as Hispanic or Latino ethnicity.

Monotherapy with Ozempic 0.5 mg and 1 mg once weekly for 30 weeks resulted in a statistically significant reduction in HbA1c compared with placebo.

Combination Therapy Use of Ozempic in Patients with Type 2 Diabetes Mellitus

- *Combination with metformin and/or thiazolidinediones*

  In a 56-week, double-blind trial (NCT01930188), 1,231 patients with type 2 diabetes mellitus were randomized to Ozempic 0.5-mg once weekly, Ozempic 1-mg once weekly, or sitagliptin 100-mg once daily, all in combination with metformin (94%) and/or thiazolidinediones (6%). Patients had a mean age of 55 years and 51% were men. The mean duration of type 2 diabetes was 6.6 years, and the mean BMI was 32 kg/m2. Overall, 68% were white, 5% were black or African American, and 25% were Asian; 17% identified as Hispanic or Latino ethnicity.

  Treatment with Ozempic 0.5 mg and 1 mg once weekly for 56 weeks resulted in a statistically significant reduction in HbA1c compared with sitagliptin.

- *Combination with metformin or metformin with sulfonylurea*

  In a 56-week, open-label trial (NCT01885208), 813 patients with type 2 diabetes mellitus who were receiving metformin alone (49%), metformin with sulfonylurea (45%), or other (6%) were randomized to Ozempic 1-mg once weekly or exenatide 2-mg once weekly. Patients had a mean age of 57 years and 55% were men. The mean duration of type 2 diabetes was 9 years, and the mean BMI was 34 kg/m2. Overall, 84% were white, 7% were black or African American, and 2% were Asian; 24% identified as Hispanic or Latino ethnicity.

  Treatment with Ozempic 1-mg once weekly for 56 weeks resulted in a statistically significant reduction in HbA1c compared with exenatide 2-mg once weekly.

- *Combination with metformin or metformin with sulfonylurea*

  In a 30-week, open-label trial (NCT02128932), 1,089 patients with type 2 diabetes mellitus were randomized to Ozempic 0.5-mg once weekly, Ozempic 1-mg once weekly, or insulin glargine once daily on a background of metformin (48%) or metformin and sulfonylurea (51%). Patients had a mean age of 57 years and 53% were men. The mean duration of type 2 diabetes was 8.6 years, and the mean BMI was 33 kg/m2. Overall, 77% were white, 9% were black or African American, and 11% were Asian; 20% identified as Hispanic or Latino ethnicity.

  Patients assigned to insulin glargine had a baseline mean HbA1c of 8.1% and were started on a dose of 10 U once daily. Insulin glargine dose adjustments occurred throughout the trial period based on self-measured fasting plasma glucose before breakfast, targeting 71 to <100 mg/dL. In addition, investigators

could titrate insulin glargine at their discretion between study visits. Only 26% of patients had been titrated to goal by the primary endpoint at week 30, at which time the mean daily insulin dose was 29 U/d.

Treatment with Ozempic 0.5-mg and 1-mg once weekly for 30 weeks resulted in a statistically significant reduction in HbA1c compared with the insulin glargine titration implemented in this study protocol.

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Ozempic injection is supplied as a clear, colorless solution that contains 2 mg of semaglutide in a 1.5 mL (1.34 mg/mL) prefilled, disposable, single-patient-use pen injector in the following packaging configurations:

Carton of 1 Pen (NDC 0169-4132-12)
- Pen delivers doses of 0.25 mg or 0.5 mg per injection
- 6 NovoFine® Plus needles
- Intended for treatment initiation at the 0.25-mg dose and maintenance treatment at the 0.5-mg dose

Carton of 2 Pens (NDC 0169-4136-02)
- Pen delivers doses of 1 mg per injection
- 4 NovoFine Plus needles
- Intended for maintenance treatment at the 1-mg dose only

Each Ozempic pen is for use by a single patient. An Ozempic pen must never be shared between patients, even if the needle is changed.

Recommended Storage

Before first use, Ozempic should be stored in a refrigerator between 36°F to 46°F (2°C to 8°C). Do not store in the freezer or directly adjacent to the refrigerator cooling element. Do not freeze Ozempic and do not use Ozempic if it has been frozen.

After first use of the Ozempic pen, the pen can be stored for 56 days at controlled room temperature (59°F to 86°F; 15°C to 30°C) or in a refrigerator (36°F to 46°F; 2°C to 8°C). Do not freeze. Keep the pen cap on when not in use. Ozempic should be protected from excessive heat and sunlight.

Always remove and safely discard the needle after each injection and store the Ozempic pen without an injection needle attached. Always use a new needle for each injection.

Ozempic is manufactured by NovoNordisk.

LITSCAN FOR CASE MANAGERS

LitScan for Case Managers reviews medical literature and reports abstracts that are of particular interest to case managers in an easy-to-read format. Each abstract includes information to locate the full-text article if there is an interest. This member benefit is designed to assist case managers in keeping current with clinical breakthroughs in a time-effective manner.

AIDS Res Hum Retroviruses. 2018 Feb 28. doi: 10.1089/AID.2017.0201

Pathways to retention in HIV care among US veterans.

Hennick M, Kaiser B, Marconi V.

Retaining HIV patients in clinical care is a critical component of the HIV care continuum, impacting not only patients' virologic suppression but their overall health and well-being. Understanding reasons for patient drop out is therefore important to improve HIV outcomes and reduce transmission. This study used qualitative in-depth interviews with patients who dropped out of HIV care (n=16) from the Atlanta Veterans Affairs Medical Center to explore their reasons for drop out and how they negotiate barriers to return to care. Results show three interlinked 'pathways' leading to patient drop out - wellness, illness, and medication pathways. These pathways encompass both barriers to retention and triggers to resume clinic visits, with patients following different pathways at different times in their lives. Perhaps the strongest deterrent to continuing clinic visits was participants' self-perception of wellness, which often outweighed clinical indicators of wellness. These pathways suggest multiple approaches are needed to improve treatment retention, including: reducing clinic-based barriers, addressing basic needs that are barriers to clinic visits, and empowering patients to view clinic visits as a facilitator to maintaining their overall health rather than only a reaction to illness.

Clin Infect Dis. 2018 Mar 2. doi: 10.1093/cid/ciy182.

Effects of pre-exposure prophylaxos for the prevention of HIV infection on sexual risk behavior in men who have sex with men: a systematic review and meta-analysis.

Traeger MW, Schroeder SE, Wright EJ, et al.

BACKGROUND: HIV pre-exposure prophylaxis (PrEP) is effective in reducing HIV risk in men who have sex with men (MSM). However concerns remain that risk compensation in PrEP users may lead to decreased condom use and increased incidence of sexually transmitted infections (STIs). We assessed the impact of PrEP on sexual risk outcomes in MSM.

METHODS: We conducted a systematic review of open-label trials and observational studies published to August 2017 reporting sexual risk outcomes (STI diagnoses, condom use, number of sexual partners) in the context of daily oral PrEP use in HIV-negative MSM and transgender women. Pooled effect estimates were calculated using random-effects meta-analysis and a qualitative review and risk of bias assessment were performed.

RESULTS: Sixteen observational studies and one open-label trial met selection criteria. Eight studies with 4388 participants reported STI prevalence and 13 studies with 5008 participants reported change in condom use. PrEP use was associated with a significant increase in rectal chlamydia (odds ratio [OR] =1.59; 95% CI, 1.19-2.13; p=0.002; heterogeneity I2 = 23%) and an increase in any STI diagnosis (OR= 1.24; 95% CI, 0.99-1.54; p=0.059; I2=50%). The association of PrEP use with STI diagnoses was stronger in later studies. Most studies showed evidence of an increase in condomless sex among PrEP users.

CONCLUSION: Findings highlight the importance of efforts to minimize STIs among PrEP users and their sexual partners. Monitoring of risk compensation among MSM in the context of PrEP scale-up is needed to assess the impact of PrEP on the sexual health of MSM and to inform preventive strategies.

Eur J Gastroenterol Hepatol. 2018 Feb 23. doi: 10.1097/MEG.0000000000001101

The safety and efficacy of ledipasvir/sofosbuvir with or without ribavirin in the treatment of orthotopic liver transplant recipients with recurrent hepatitis C: real-world data.

Pyrsopoulos N, Trilianos P, Lingiah VA, Fung P, Punnoose M.

BACKGROUND: Recurrent hepatitis C (RHC) in orthotopic liver transplantation (OLT) population is associated with accelerated rates of fibrosis, low efficacy and decreased tolerability with traditional therapies. AIM: The aim of this study was to evaluate

the safety and efficacy of ledipasvir/sofosbuvir (LED/SOF) with or without ribavirin (RBV) in OLT patients with RHC.

PATIENTS AND METHODS: Patients at least 3 months post-OLT and with documented RHC were treated with LED/SOF with or without RBV for either 12 or 24 weeks. End-of-treatment and sustained virological response 12 weeks after the completion of treatment were documented. Patients were closely monitored for treatment-related adverse effects and the potential need for adjustment in their immunosuppression.

RESULTS: Seventy-one patients were included in the study. Median age was 62 years. Median time from OLT was 55 months. Twenty-six (36.6%) patients were treatment-naive and 45 (63.4%) had previously failed interferon-based therapies. The majority of patients (57.7%) had stage F0-F2 fibrosis. Sixty-seven (94.3%) patients completed 12 weeks of LED/SOF with RBV, three patients completed 12 or 24 weeks of LED/SOF without RBV, and one patient completed only 8 weeks of LED/SOF without RBV owing to severe allograft dysfunction. Sustained virological response was near universal in our cohort (98.5%) regardless of genotype, fibrosis stage, and regimen or treatment duration. Most commonly reported side effects were malaise and gastrointestinal upset. No patient required adjustment in immunosuppression and no episodes of rejection were documented during treatment.

CONCLUSION: The combination of LED/SOF with RBV for 12 weeks or LED/SOF for 24 weeks is very effective and safe in treating OLT recipients with RHC.

Clin Cardiol. 2018 Mar 7. doi: 10.1002/clc.22937

Importance of baseline heart rate as a predictor of cardiac functional recovery in newly diagnosed heart failure with reduced ejection fraction.

Valika A, Paprockas K, Villines, D, Costanzo MR.

BACKGROUND: Left ventricular ejection fraction (LVEF) has shown to predict outcomes in patients with heart failure (HF). Left ventricular recovery (LVR) has shown to improve prognosis.

HYPOTHESIS: Guideline directed medical therapy (GDMT) will predict LVR in patients with HF and reduced EF.

METHODS: 244 patients with newly diagnosed HF and a LVEF ≤ 35% were studied. LVR was defined as an increase in LVEF ≥ 40%. Patients who experienced LVR were compared to those who had persistent left ventricular dysfunction (LVD). RESULTS: Population characteristics included: ischemic etiology = 38.1%; baseline EF = 23% ± 6%; mean baseline heart rate (HR) = 75 ± 13 bpm. GDMT was achieved as follows: ACE inhibitors (ACEi) = 74.3%; Beta blocker (BB) = 95.4%; target dosing ACEi = 33.7%; target dosing BB = 40.2%. LVR occurred in 154/244 patients (63.1%). By multivariable analysis, baseline heart rate ≤ 70 bpm was the only independent predictor of LVR (OR = 3.39, 95% CI = 1.5-7.5, p = 0.003). Target dosing of BB therapy was predictive of LVR only in the univariate analysis (OR = 1.9, 95% CI =1.1-3.4, p=0.03). Furthermore, the composite endpoint HF hospitalization or death occurred less frequently in those who did versus those who did not achieve target BB doses (5.4% vs. 16.7%, p = 0.023).

CONCLUSION:The novel findings of our analysis reveal the only predictor of LVR in this study was a low baseline HR. Early modulation of heart rate in newly diagnosed HF patients may increase the rates of LVR.

Am J Cardiol. 2018 Jan 31. pii: S0002-9149(18)30112-7. doi: 10.1016/j.amjcard.2017.12.044.

Impact of advanced therapies for improving survival to heart transplant in patients with hypertrophic cardiomyopathy.

Rowin EJ, Maron BJ, Abt P, et al.

Heart transplant has become an increasingly important option for patients with end-stage nonobstructive hypertrophic cardiomyopathy (HC). However, clinical details related specifically to the overall HC transplant experience remain sparse. We assessed outcomes of HC heart transplants, from 2002 to 2016, at Tufts Medical Center. Fifty-two nonobstructive severely symptomatic patients underwent evaluation at 47 ± 13 years; 11 (21%) declined or failed to qualify, most commonly because of co-morbidities (n = 7). Of the remaining 41 patients ultimately listed, 6 (15%) died of heart failure awaiting transplant (11%/year), 26 underwent transplant, and 9 remained active on the list. Survival rates on the waiting list depended on ≥1 treatment intervention: inotropic medications (n = 20), ventricular assist devices (n = 7), or implantable defibrillators terminating ventricular tachyarrhythmias (n = 7). Of the 26 transplanted patients, 24 survived for 4.8 ± 3.4 years (up to 12), including 23 who are currently alive. The survival rate 5 years post transplant is 92%. Compared with heart transplants for other cardiomyopathies, patients with HC had similar mortality while wait-listed and post transplant (p = 0.77 and 0.13, respectively). In conclusion, a large proportion of patients with HC considered for transplant ultimately received hearts and experienced excellent

short- and long-term survival rates. The survival rate on the waiting list was directly attributable to major interventions: implantable cardioverter-defibrillators, inotropic drugs, and ventricular assist devices, and the perception that patients with HC have low wait-list mortality risk does not appear justified. Neither normal ejection fraction nor peak oxygen consumption > 14 ml/kg/min should exclude drug refractory severely symptomatic patients with HC from heart transplant consideration.

J Heart Lung Transplant. 2017 May;36(5):499-508. doi: 10.1016/j.healun.2017.01.007. Epub 2017 Jan 6.

Efficacy of a medication adherence enhancing intervention in transplantation: The MAESTRO-Tx trial.

Dobbels F, De Bleser L, Bergen L, et al.

BACKGROUND:Well-designed randomized controlled trials (RCTs) testing efficacy of post-transplant medication adherence enhancing interventions and clinical outcomes are scarce.

METHODS: This randomized controlled trial enrolled adult heart, liver, and lung transplant recipients who were >1 year post-transplant and on tacrolimus twice daily (convenience sample) (visit 1). After a 3-month run-in period, patients were randomly assigned 1:1 to intervention group (IG) or control group (CG) (visit 2), followed by a 6-month intervention (visits 2-4) and a 6-month adherence follow-up period (visit 5). All patients used electronic monitoring for 15 months for adherence measurement, generating a daily binary adherence score per patient. Post-intervention 5-year clinical event-free survival (mortality or retransplantation) was evaluated. The IG received staged multicomponent tailored behavioral interventions (visits 2-4) building on social cognitive theory and trans-theoretical model (e.g., electronic monitoring feedback, motivational interviewing). The CG received usual care and attended visits 1-5 only. Intention-to-treat analysis used generalized estimating equation modeling and Kaplan-Meier survival analysis.

RESULTS: Of 247 patients, 205 were randomly assigned (103 IG, 102 CG). At baseline, average daily proportions of patients with correct dosing (82.6% IG, 78.4% CG) and timing adherence (75.8% IG, 72.2% CG) were comparable. The IG had a 16% higher dosing adherence post-intervention (95.1% IG, 79.1% CG; $p < 0.001$), resulting in odds of adherence being 5 times higher in the IG than in the CG (odds ratio 5.17, 95% confidence interval 2.86-9.38). This effect was sustained at end of follow-up (similar results for timing adherence). In the IG, 5-year clinical event-free survival was 82.5% vs 72.5% in the CG ($p = 0.18$).

CONCLUSION: Our intervention was efficacious in improving adherence and sustainable. Further research should investigate clinical impact, cost-effectiveness, and scalability.

Am J Hypertens. 2017 Jun 1;30(6):587-593. doi: 10.1093/ajh/hpx028.

Association of blood pressure trajectory with mortality, incident cardiovascular disease, and heart failure in the Cardiovascular Health Study.

Smitson CC, Scherzer R, Shlipak MG, et al.

BACKGROUND: Common blood pressure (BP) trajectories are not well established in elderly persons, and their association with clinical outcomes is uncertain.

METHODS: We used hierarchical cluster analysis to identify discrete BP trajectories among 4,067 participants in the Cardiovascular Health Study using repeated BP measures from years 0 to 7. We then evaluated associations of each BP trajectory cluster with all-cause mortality, incident cardiovascular disease (CVD, defined as stroke or myocardial infarction) (N = 2,837), and incident congestive heart failure (HF) (N = 3,633) using Cox proportional hazard models.

RESULTS: Median age was 77 years at year 7. Over a median 9.3 years of follow-up, there were 2,475 deaths, 659 CVD events, and 1,049 HF events. The cluster analysis identified 3 distinct trajectory groups. Participants in cluster 1 (N = 1,838) had increases in both systolic (SBP) and diastolic (DBP) BPs, whereas persons in cluster 2 (N = 1,109) had little change in SBP but declines in DBP. Persons in cluster 3 (N = 1,120) experienced declines in both SBP and DBP. After multivariable adjustment, clusters 2 and 3 were associated with increased mortality risk relative to cluster 1 (hazard ratio = 1.21, 95% confidence interval: 1.06-1.37 and hazard ratio = 1.20, 95% confidence interval: 1.05-1.36, respectively). Compared to cluster 1, cluster 3 had higher rates of incident CVD but associations were not statistically significant in demographic-adjusted models (hazard ratio = 1.16, 95% confidence interval: 0.96-1.39). Findings were similar when stratified by use of antihypertensive therapy.

CONCLUSIONS: Among community-dwelling elders, distinct BP trajectories were identified by integrating both SBP and DBP. These clusters were found to have differential associations with outcomes.

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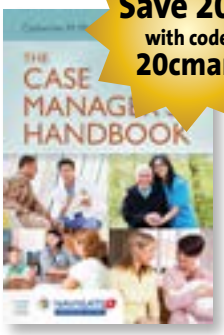

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J Hum Hypertens. 2017 Feb;31(2):106-115. doi: 10.1038/jhh.2016.47. Epub 2016 Jul 28.

The role of compliance with PAP use on blood pressure in patients with obstructive sleep apnea: is longer use a key-factor?

Bouloukaki I, Mermigkis C, Tzanakis N, et al.

Scientific data about the effects of positive airway pressure (PAP) treatment on blood pressure (BP) control are continuously increasing; however, they are controversial. We aimed to determine the long-term effects of compliance with PAP therapy on BP in both hypertensive and normotensive patients with obstructive sleep apnea-hypopnea syndrome (OSAHS). One thousand one hundred sixty eight consecutive patients with newly diagnosed OSAHS, who had been recommended PAP therapy, were followed up for a minimum of 2 years. Patients with previous cardiovascular disease were excluded. BP was measured at baseline and after 2 years of PAP treatment. In addition, the correlation between the changes in BP with different levels of PAP compliance was assessed. At the end of the follow-up period, in the hypertensive group of patients (n=586), a significant decrease was shown in systolic (-11.2 mm Hg, P<0.001) and diastolic BP (-4.2 mm Hg, P<0.001). Furthermore, in the patients without hypertension (n=528), a significant decrease was noted both in systolic and diastolic BP (-3.6, P<0.001 and -2.4, P<0.001, respectively). A correlation between the magnitude of change in systolic and diastolic BP and hours of use of PAP (r=0.14, P=0.002 and r=0.1, P=0.025, respectively) was observed in all patients. Long-term use of PAP treatment, as well as increased hours of PAP in patients with OSAHS use showed significant reductions in BP not only in patients with hypertension, but also in normotensive patients. Therefore a significant potential reduction in cardiovascular mortality and morbidity should be expected in these patients.

J Am Heart Assoc. 2018 Feb 28;7(5). pii: e008142. doi: 10.1161/JAHA.117.008142.

Risk factors for major early adverse events related to cardiac catheterization in children and young adults with pulmonary hypertension: an analysis of data from the IMPACT (Improving Adult and Congenital Treatment) Registry.

O'Byrne ML, Kennedy KF, Kanter JP, Berger JT, Glatz AC.

BACKGROUND: Cardiac catheterization is the gold standard for assessment and follow-up of patients with pulmonary hypertension (PH). To date, there are limited data about the factors that influence the risk of catastrophic adverse events after catheterization in this population.

METHODS AND RESULTS: A retrospective multicenter cohort study was performed to measure risk of catastrophic adverse outcomes after catheterization in children and young adults with PH and identify risk factors for these outcomes. All catheterizations in children and young adults, aged 0 to 21 years, with PH at hospitals submitting data to the IMPACT (Improving Adult and Congenital Treatment) registry between January 1, 2011, and December 31, 2015, were studied. Using mixed-effects multivariable regression, we assessed the association between prespecified subject-, procedure-, and center-level covariates and the risk of death, cardiac arrest, or mechanical circulatory support during or after cardiac catheterization. A total of 8111 procedures performed in 7729 subjects at 77 centers were studied. The observed risk of the composite outcome was 1.4%, and the risk of death before discharge was 5.2%. Catheterization in prematurely born neonates and nonpremature infants was associated with increased risk of catastrophic adverse event, as was precatheterization treatment with inotropes and lower systemic arterial saturation. Secondary analyses demonstrated the following: (1) increasing volumes of catheterization in patients with PH were associated with reduced risk of composite outcome (odds ratio, 0.8 per 10 procedures; P=0.002) and (2) increasing pulmonary vascular resistance and pulmonary artery pressures were associated with increased risk (P<0.0001 for both).

CONCLUSIONS: Young patients with PH are a high-risk population for diagnostic and interventional cardiac catheterization. Hospital experience with PH is associated with reduced risk, independent of total catheterization case volume.

Ann Thorac Surg. 2018 Mar 1. pii: S0003-4975(18)30262-5. doi: 10.1016/j.athoracsur.2018.01.075.

Lung cancer screening in the community setting.

Cattaneo SM II, Meisenberg BR, Geronimo MCM, Bhandari B, Maxted JW, Brady-Copertino CJ.

BACKGROUND: Lung cancer has high incidence and high mortality burden particularly since it is typically diagnosed in later stages. The National Lung Screening Trial demonstrated a lung cancer specific mortality benefit in high risk current and former smokers with yearly low dose chest CT. Lung cancer screening

continues on page 35

Beta-Blockers May Raise Mortality in Those With Diabetes and Heart Disease

Beta-blocker use may be contraindicated in patients with diabetes and coronary heart disease (CHD), according to a prospective cohort study using data from the US National Health and Nutrition Examination Survey 1999-2010; the study included 2,840 people with diabetes (697 taking beta-blockers; 2,143 not) and 14,684 people without diabetes (1,584 taking beta-blockers; 13,100 not). Findings were that adjusted all-cause mortality in the diabetes group was significantly higher with than without beta-blockers (adjusted hazard ratio [aHR], 1.49; P = .01), with similar results for those taking $beta_1$-selective (1.60; P = .007) vs specific beta-blockers (1.55; P = .01).

Among those without diabetes, no significant difference was seen with or without beta-blockers (aHR, 0.99; P = .96). All-cause mortality in the group with diabetes and CHD was significantly higher with vs without beta-blockers (aHR, 1.64; P = .02), whereas all-cause mortality in those with CHD and no diabetes was significantly lower with beta blockers (0.68; P = .02).

Similar patterns were found for those with a history of myocardial infarction and congestive heart failure and in propensity score–matched analysis. ■

CMSA's Opioid Use Disorder Case Management Guide

CMSA has announced the release of the *Opioid Use Disorder Case Management Guide*.

The Guide was developed in collaboration with Reinsurance Group of America's ROSE program and authored by CMSA's Executive Director, Kathleen Fraser, and CMSA Program Director, Rebecca Perez.

This guide will assist case managers and other health care professionals in assessment, care planning process, and intervention development to address opioid use disorder.

If there is one issue that is more pressing than ever it would be the national opioid crisis. The abuse of opioids is a global problem that affects the health as well as the social and economic welfare of societies. Download a copy today. ■

New Wound Care Device Helps to Heal Pressure Ulcers

A new wound care device that uses nitric oxide can heal diabetic foot ulcers faster and more effectively than current standard care, according to the Edinburgh-based developer Edixomed. The system is called EDX110. According to the developer, the device heals diabetic foot ulcers twice as fast as standard care dressings. A "real world" trial assessed the safety and efficacy of the EDX110 device for the treatment of diabetic foot ulcers compared with optimal standard care. The study can be read in full at *Wound Repair and Regeneration*. ■

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Suicide Risk Often Sharply Higher for Patients With Neurologic Disorders

Danish researchers have found that the risk of suicide attempt by self-poisoning is elevated in 9 of 10 neurologic disorders. The risk was elevated among patients with stroke (odds ratio [OR], 3.1; P < .0001), Huntington's disease (OR 8.8; P < .0001), amyotrophic lateral sclerosis (OR, 5.0; P = .0033), Parkinson's disease (OR, 2.9; P < .0001), Alzheimer's disease and other degenerative diseases (OR, 4.8; P < .0001), multiple sclerosis (OR, 1.5; P = .0060), epilepsy (OR, 4.5; P < .0001), hereditary and idiopathic neuropathy (OR, 2.2; P = .026), and myasthenia gravis (OR, 4.3; P = .0003).

The findings were generally similar after adjustment for chronic nonpsychiatric and psychiatric comorbidities. Abuse of alcohol and other psychoactive substances partly explained associations seen for epilepsy and Alzheimer's disease. The risk for suicide attempt is higher for men than for women with neurologic disorders (OR, 4.2 vs 3.3; P = .0026). ■

Alternative Medicine Increases Rates of Mortality for Cancer Patients

A Yale University study of 280 cancer patients showed that, after 5 years, only 54.7% of the people who relied on alternative therapies were still alive, whereas 78.3% of people who received medical treatment survived. When specific types of cancer were studied, death from lung cancer doubled and death from colorectal cancer quadrupled for those who opted for homeopathic therapies. ■

CMS CLARIFIES "IMPROVEMENT STANDARD" TO THE BENEFIT OF PERSONS SERVED

Recent CMS actions provide welcome clarity to providers, insurers, and individuals with chronic conditions who need rehabilitative therapies and other skilled services, even when their underlying condition will not improve.

The actions include revisions to the Medicare Benefit Policy Manual, a CMS webpage devoted to the topic, and a nationwide education campaign. Among the changes are the following:

- Maintenance-coverage standard: Medicare coverage is available for skilled services to maintain an individual's condition. Medicare coverage turns on whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will "improve."
- Medically necessary nursing and therapy services, provided by or under the supervision of skilled personnel, are coverable by Medicare if the services are needed to maintain the individual's condition or to prevent or slow their decline. In other words, maintenance services can be skilled, performed by a skilled therapist or nurse, and covered by Medicare.
- CMS must develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve. ■

DNA BLOOD TEST SUCCESSFULLY DETECTS EARLY-STAGE CANCER

According to the Cancer Institute, a DNA blood test screens for cell-free circulating tumor DNA (ctDNA), pieces of DNA that are released into the bloodstream by dying tumor cells. It has detected early-stage cancer in people with the deadliest forms of cancer including breast, colon, lung, and ovarian cancer. For those already diagnosed with stage 1 cancer, the test found cancer in the blood of over half those tested. The blood test was more successful with detecting cancer in later-stage cancers. It is still in the research phase, but it is a move in the right direction for detecting early-stage cancer. For more information. ■

Opioids Are Top Concern of US Mayors

The Bloomberg Philanthropies 2018 American Mayors Survey, the largest and most comprehensive survey of mayors to date, reports that:

- Nationally, 32% said that misuse of opioids is one of the top challenges facing their city, and 42% of mayors said it is one of the many challenges facing their city.
- Across the country, 40% of mayors report creating new programs within the last 12 months to address the opioid crisis.
- Of the programs that exist, 62% support wide distribution of naloxone (Narcan) by law enforcement; only 20% of cities have a written plan in place to address the epidemic. ■

CMSA Elects New Board Members

CMSA's membership has elected 2 members to move into 3-year national director roles on the CMSA National Board of Directors. In addition, CMSA's current president-elect will move into a new role as president and the current president will move into the role of immediate past president. These leaders will begin their terms at the end of CMSA's 28th Annual Conference & Expo held this year in Chicago, Illinois, the week of June 19-23, 2018. Board members include Jose Alejandro, PhD, RN-BC, CCM, FACHE, FAAN, as president; Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM, as past president; and Catherine Campbell, MSN, MBA, RN, CHC, FACHE, CCM, and Andrea Norton, BSN, RN, CCM, as directors. ■

Violence Within Hospitals

OSHA.gov reports that violent injuries in the health care industry accounted for almost as many violent injuries as all other industries combined—even more than police officers and prison guards.

Approximately 1 in 4 nurses have reported being physically assaulted on the job within the past year.

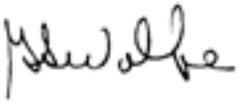
Changes are underway. On July 19, 2017, the House-Senate Public Safety Committee approved Elise's Law requiring health care employers to implement workplace violence prevention plans. Furthermore, the bill requires employers to give injured employees paid time off while dealing with legal issues. ■

Workforce Trauma: The Impact of Case Managers *continued from page 2*

d. Seek professional help if the symptoms do not decrease after a reasonable time. You may want to consider getting some additional help through an EAP program (if available) or through a mental health professional. Prompt attention to traumatic stress can often minimize long-term effects.

Bad things happen, and sometimes these bad things involve injury and even death. However, trauma can occur even without death. If workforce trauma is recognized, it will become obvious these events will have an impact on you and the people your work with. By taking some time at the front end to plan for preventing or minimizing traumatic events and to respond when they occur, much of the negative impact of such events can be mitigated.

Workforce trauma will never stop, but it can be significantly decreased. That will happen when each of us does something to stop it. Be alert for people in distress; show kindness, respect and humility; and go out of your way to help those in need.



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ACCM: Improving Case Management Practice through Education

Getting Certified, Staying Certified, and Developing Others
continued from page 4

for clients within a complex and fragmented health care system.

Looking ahead, given the aging of the population and the increased incidence of chronic conditions and complex cases, and as the number of employers recognizing the value of certification continues to grow, there will be more advantages in the future to get certified and stay certified. CM

Certification: The Professional "Calling Card" *continued from page 10*

a price tag associated with them, which requires fiduciary oversight and accountability for the organization from both a quality and financial perspective. To meet these demands, certified professionals need to invest in continuing education that does not just follow one track but also expands the breadth of their knowledge so that they can stay abreast of current policies and evidence-based practices.

As disability management specialists and disability case managers, we come from professional disciplines such as rehabilitation, nursing, occupational health, and similar fields. But our expertise doesn't end there. Those of us with the CDMS and/or the CCM certifications, as well as other well-respected credentials, have the proven skills to manage complex processes, which makes us even more valuable to employers today. As we pursue opportunities to help employers manage the cost and impact of absences and support a healthier and more-productive workforce, we will need the calling cards of our credentials and certifications to open the door. CM

CE 1 Care Management in the Correctional Setting
continued from page 15

Care management of patients in the correctional setting has become a priority to provide safe medical care as well as preventative care to both incarcerated individuals and to the surrounding population. The case management needs within this specialty have exploded in recent years. CE 1

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CE II Workforce Trauma: An Evolving Concern for Case Management *continued from page 21*

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2018 CARF Medical Rehabilitation Standards Manual: New Standards and Reorganization *continued from page 11*

appraisal standard allows for the wide array of practices that are now being used in this critical part of development and management of the workforce. For the first time there is also a standard that addresses succession planning from future workforce needs, gap analysis, and strategic development.

CARF staff are available via email or phone to answer any questions you may have. Please reach out to learn more about the changes in 2018.

The Medical Rehabilitation Standards Manual has also aligned with other Manuals of CARF by reorganizing their Manual into 4 sections:

- Section 1—ASPIRE to Excellence
- Section 2—Rehabilitation Process and Services
- Section 3—Program Standards including:
  - –Comprehensive Integrated Inpatient Rehabilitation Program
  - –Outpatient Medical Rehabilitation
  - –Home and Community Services
  - –Residential Rehabilitation
  - –Vocational Rehabilitation
  - –Interdisciplinary Pain Rehabilitation
  - –Occupational Rehabilitation Program
  - –Independent Evaluation Services
  - –Case Management
- Section 4—Specialty Program Designation Standards
  - –Pediatric Specialty Program
  - –Amputation Specialty Program
  - –Brain Injury Specialty Program
  - –Cancer Rehabilitation Specialty Program
  - –Spinal Cord Specialty Program
  - –Stroke Specialty Program

We will also be doing CARF 101s, a 2-day intensive training on the standards June 11–12, 2018, in Minneapolis, Minnesota, and October 15–16 in San Diego, California.

We look forward to receiving your comments and questions. Please contact us at cmacdonell@carf.org. CM

LITSCAN FOR CASE MANAGERS

continued from page 30

is thus recommended but it is unclear if the results of the National Lung Screening Trial can be replicated in community settings.

METHODS:A retrospective review was performed of the lung screening program over its first five years, 2012-2016. Patient demographics, initial screening results, follow up, and management results were analyzed in relation to the National Lung Screening Trial results. Annual adherence was defined as returning for imaging within one year + 90 days.

RESULTS: 1241 persons underwent initial screening over the 5-year period. 78.6% of findings were benign and only annual repeat low dose chest CT was recommended. 29 cancers were identified in 26 participants (2%) of which 72% were stage I. Annual adherence rate to repeat imaging after low risk baseline scan was 37% and any follow up rate was 51% despite programmatic efforts to follow screening recommendations. When positive findings required more intensive evaluation, most commonly by repeat chest CT scan, adherence was 88%. 1.1% of all participants had invasive biopsies for benign results. Complications of biopsy were minimal.

CONCLUSIONS: Our review demonstrates that a community-based program can approximate the results of the National Lung Screening Trial in detecting early lung cancers. Further study of the adherence phenomenon is essential.

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