CareManagement

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Post-Conference Special Edition

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Gary S. Wolfe

The Opioid Epidemic: A Public Health Challenge

Every day, more than 130 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.

Opioids are a class of drugs that are derived from opium. Morphine is the most naturally found opioid in opium and was used as a pain reliever for years. As medicine and science advanced, we found ways to replicate the effect of morphine. Examples of common opioids include codeine, meperidine (Demerol,® sanofi-aventis U.S. LLC, Bridgewater, NJ), hydromorphone (Dilaudid,® Abbott Laboratories, North Chicago, IL), fentanyl, heroin, hydrocodone, methadone, morphine, oxycodone, and tramadol.

Some sobering statistics:

- Around 68% of all drug overdoses in 2017 involved opioids.
- In 2017 the number of overdose deaths involving opioids was 6 times higher than in 1999.
- 80% of those who are addicted to opioids started with a prescription for an opioid pain reliever.
- Overdoses fueled by opioids are the leading cause of deaths for those under the age of 50 (more than guns or car accidents), and opioids are causing deaths at a faster rate than the AIDS epidemic at its peak.
- Approximately 25% of individuals who are prescribed opioids for pain misuse them.
- Approximately 10% of individuals who are prescribed opioids develop an opioid use disorder.
- There is a rising incidence in neonatal abstinence syndrome because of opioid use and misuse during pregnancy.
- The increase in injection drug use has been associated with an increase in infectious diseases such as hepatitis C and HIV infection.

The misuse of prescription pain killers contributed to the opioid epidemic. Some of the reasons people misuse prescriptions include to relieve physical pain, to reduce or relieve tension, to experiment or see what the drug is like, to feel good or get high, to help with sleep issues, to help with feelings or emotions, and to increase or decrease the effects of other drugs.

This epidemic didn't just happen overnight; it is been brewing for 20 years. The 1990s saw a significant increase in prescription opioids and in deaths from overdoses. As pharmaceutical companies were looking for new pain killers, they begin to promote synthetic and semisynthetic opioids to prescribers. The promotions would say that opiods were not addictive or that they were less addictive than morphine with no serious side effects. Prescribers believed that there would be no repercussions if their patients took them. This growth in prescribing pushed the use of opioids, which continues to this day. Beginning in 2010, there was a rapid increase in heroin overdoses.

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Certification: The "Business Case" for Employers

Michelle Baker, BS, RN, CRRN, CCM, and MaryBeth Kurland, CAE

Certification is the next step for case managers seeking professional growth and advancement. While board certification such as the Certified Case Manager® (CCM®) credential is achieved on an individual basis, organizations that employ case managers reap the benefits as well.

Increasingly, employers require certification for case managers. The Commission for Case Manager Certification (CCMC), in its ongoing field research, has documented a growing number of employers that stipulate certification as a condition of employment. In addition, many employers offer a financial incentive for those who are certified. These employers understand that, by attaining the CCM credential, case managers are required to uphold the highest professional and ethical standards, including meeting requirements for ongoing education in the field of case management.

As more employers recognize the importance of hiring and retaining CCMs, it further validates CCMC's broad 3-part plan for professionals in the field: to get certified, stay certified, and develop others. The relevance of certification to both case managers and their employers further enhances the third pillar of "develop others," which looks to the future with the knowledge that more experienced and highly valued case managers are heading toward retirement and others must take their place. Therefore, employers can do their part in encouraging case managers to become certified as there is a clear "business case" for certification. When case managers are certified, their employers gain the peace of mind that the professionals providing case management services are up to date on trends in the field and have received training on ethical dilemmas that can result, particularly when handling complex cases.

In the pursuit of certification, there are clear expectations defined by CCMC in its eligibility guidelines as to the scope of responsibilities for professional case managers. To be eligible, the case manager's job description must include elements of case management practice such as conducting individual assessments and also planning, implementing, and evaluating the services delivered as part of a care plan. This further enables employers to provide assurance to their customers (ie, insurers, hospitals, or other organizations) regarding the quality of case management services delivered to specific populations: "clients" of case management, "members" of insurance plans, "injured workers" covered by workers' compensation, or "patients" in the healthcare system.

CCMs are trained to work on and lead teams. As board-certified professionals, they contribute to the effectiveness of interdisciplinary teams, raising the bar among the professional group with whom the case manager interacts. Other health and human services professionals understand that when a CCM is on the team, that colleague has the requisite skills and knowledge to practice independently and is committed to evidence-based practice, with the individual at the center. As CCMs interact with licensed and credentialed health and human services professionals from multiple disciplines, such as a Certified Disability Management Specialist (CDMS), certification establishes the common

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The Commission for Case Manager Certification (CCMC), in its ongoing field research, has documented a growing number of employers that stipulate certification as a condition of employment.

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MaryBeth Kurland, CAE, *is CEO of CCMC, which currently certifies more than 45,000 professional case managers and nearly 2,600 disability management specialists. The Commission is a nationally accredited nonprofit volunteer organization that oversees the process of case manager certification with its CCM® credential and the process of disability management specialist certification with its CDMS® credential.*

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Facilitating Return to Work for Mental Health Diagnoses

Lisa M. Scotton, MJ, RN, CCM, CDMS

As the incidence of mental illness is increasingly recognized, its impact on the workplace also needs to be acknowledged and addressed. According to the National Alliance on Mental Illness, approximately 1 in 5 adults in the United States experiences mental illness in a given year. A World Health Organization study identified depression as the leading cause of illness and disability worldwide; it estimated that depression and anxiety disorders cost the global economy $1 trillion dollars a year in lost productivity.

Employees who receive treatment for their mental health may require work accommodations that are different than, and perhaps not as obvious as, requirements for a physical diagnosis. In both situations, the key to a successful return to work (RTW) is to create a sustainable RTW plan.

Employees who receive treatment for their mental health may require work accommodations that are different than, and perhaps not as obvious as, requirements for a physical diagnosis.

While individuals with mental health diagnoses may want to return to work, just the thought of doing so may be overwhelming. Yet, when an individual is responding to a therapeutic regimen, work also can be therapeutic. A Certified Disability Management Specialist (CDMS) can be instrumental in facilitating a supportive and successful RTW plan.

Developing the RTW plan and suggesting work accommodations for mental health diagnoses can be challenging when the need for restrictions is not visibly obvious. Yet, the longer the individual remains out of work, the more strategic the RTW plan needs to be. Here are some strategies that may be helpful in developing the RTW plan. Strategies may not be practical for all jobs, so the CDMS needs to carefully review the individual's essential job functions as well as the person's diagnosis and response to treatment.

- Monitor the individual's response to treatment by communicating regularly. Offer support that advocates a safe and sustainable RTW as a plan is developed. Conduct periodic check-ins to monitor effectiveness.
- Solicit from and/or suggest to the health provider potential work modifications that might assist the individual.
- Weigh the appropriateness of a gradual RTW schedule to ease the anxiety of resuming a full-time workload after returning from leave. For example, the person can return initially on a part-time basis or with reduced work hours, which are gradually increased to full time.
- Consider flexibility with work breaks, rather than a fixed schedule, to support the individual's needs. Allow the individual to attend weekly therapy appointments.
- Avoid tasks that require driving, operating machinery, and/or working at unprotected heights as some antidepressants and antianxiety medications can cause drowsiness.

In addition, the CDMS can discuss potential workplace accommodations with the employer. If the person's concentration is impacted, explore how distractions or noise could be reduced. For example, the person may move from working in a high-traffic area to a quieter space. White noise machines or

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CCMC is the first and largest nationally accredited organization that certifies more than 45,000 professional case managers and over 2,600 disability management specialists. The Commission oversees the process of case manager certification with its CCM® credential and the process of disability management specialist certification with its CDMS® credential.

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Aligning Incentives: Diagnosis-Related Groups

Shawn Z. Stewart, DNP, RN, CCM, CCDS

Reduction in the cost of health care has been a priority for decades. During this time there have been a plethora of changes targeted at this goal and countless task forces working under 8 administrations, resulting in thousands of sweeping amendments in legislation, regulation, and increased oversight. Despite the resources allocated from both private industry and government agencies, the costs of health care have increased exponentially. Health care expenditures in 1980 were 8.9% of the national gross domestic product (GDP); distressingly, forecasted health expenses for 2018 are in excess of 18.2% of the GDP.[1]

In 1983, diagnosis-related groups (DRGs) were first introduced in the United States as a system to classify hospital cases and standardize reimbursements.[2] In tandem, the prospective payment system (PPS) was established as the default reimbursement system. Commencement of the DRG/PPS system resulted in a predetermined reimbursement amount categorized by diagnosis. The drastic conversion of health care reimbursement afforded a significant financial paradigm shift from the hospital to the payer, preventing the inevitable insolvency of Medicare.

Shawn Z. Stewart, DNP, RN, CCM, CCDS, is the Vice President of Clinical Operations at Clearlink Partners, LLC.

Utilization review was a byproduct of the DRG reimbursement system to promote organizational accountability and prevent inefficiencies that could result in financial penalties. However, it does not identify physician practice patterns of overutilization as an area of focus. The facilities are reimbursed at a predetermined case rate, while the clinical providers are reimbursed on a per diem basis. This results in varying treatment approaches rooted in conflicted priorities. The DRG system inherently prioritized payment-driven care versus individualized patient-centered care.

Health care expenditures in 1980 were 8.9% of the national gross domestic product (GDP); distressingly, forecasted health expenses for 2018 are in excess of 18.2% of the GDP.

For example, if a plan denied 3,921 inpatient days for a calendar year, the resulting payments would be $0.00 for the facility; however, the clinical providers would be reimbursed regardless because of the DRG payment methodology. Take an average of $128.00 x 3,921 days = $501,888. This calculation is reflective of one attending and consultant per day with a combined average cost of approximately $128.00 per day. The $501,888.00 is representative of the actual cost savings that would be realized upon realignment of reimbursement structures of clinical providers to match facility reimbursement structure.

The DRG system has adapted and matured congruently with technological and sociological progressions (eg, ICD-10 [International Classification of Diseases, Tenth Revision], APR-DRGs (All Patient Refined-Diagnosis Related Groups], Coding Clinics) while neglecting to undergo financial evolutionary adaptation. Thirty-five years later, contractual agreements are still perpetuating the financial inequalities originating with the DRG system. Change can be effectuated by aligning incentives of the clinical providers and the facilities. Imagine as a consumer, clinical provider, facility, and stakeholder the potential benefits of aligning to a shared accountability paradigm. CM

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Patients' Preferences for Caregivers

By Elizabeth Hogue, Esq.

A registered nurse (RN) recently sued a hospital on the basis that she was discriminated against because the hospital granted a patient's request for no African-American caregivers. According to her lawsuit, the nurse was required to switch patients with a Caucasian nurse when she was assigned to the patient's floor. A recent study conducted by WebMD and Medscape entitled "Patient Prejudice: When Credentials Aren't Enough" indicates that 20% of physicians have reported offensive remarks about their race from patients. As providers know, it is not unusual for patients to express preferences for certain types of caregivers. Managers have been asked by patients not to provide caregivers who are "foreign," for example. The question is whether such requests should be honored.

A recent study conducted by WebMD and Medscape entitled "Patient Prejudice: When Credentials Aren't Enough" indicates that 20% of physicians have reported offensive remarks about their race from patients.

Such requests should be rejected, especially when they involve discrimination based on race, religion, or any other basis commonly used to treat groups of people differently. Legally and ethically, providers should

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CCMC New World SYMPOSIUM® 2019
IT STARTS WITH US

Highlights from CCMC's New World Symposium 2019

By Jennifer Maybin, *Executive Editor,* CareManagement

The CCMC New World Symposium 2019, held at the Gaylord National Resort & Convention Center in National Harbor, Maryland, promoted the theme "It Starts With Us" and attracted more than 500 attendees and 65 exhibitors on February 27 through March 2, 2019. The Symposium kicked off with a session titled "Get Certified. Stay Certified. Develop Others," that reflects the organization's mission.

MaryBeth Kurlander, CCMC's CEO, announced collaborations with the Case Management Society of America (CMSA) and National Association of Social Workers (NASW), in which those certified by NASW are prequalified to take the CCMC certification exam for case managers.

Kurlander also reminded the audience that the Patrice V. Sminkey Memorial Foundation is accepting scholarship applications through April 30, 2019. Patrice was the former CEO of CCMC. Applications are accepted twice a year. The next window is September 1 to October 31, 2019. To further CCMC's mission, the organization has launched a comprehensive Develop Others Toolkit to develop the next generation of professional case managers.

Following these announcements, Kurlander introduced the session moderator Jeannie LeDoux, RN, BSN, MBA, CCM, CPHQ, CTT+, to speak about mentoring. LeDoux led a panel of speakers including Chikita Mann, MSN, RN, CCM; Sue Jensen, RN, PhD, CCM, MSCC; Sheila Nelson, MSN, RN, CCM; Teresa Yancey, RN, JD, CCM; and Sandra Zawalski, MSN, RN, CRRN, CCM, ABDA, MSCC. "Why mentor?" LeDoux asked. The panel noted that sharing a positive experience of mentoring cannot be underestimated in providing encouragement to new case managers and developing good working relationships. Mentors develop personal connections; share respect, learning, and values;

Attendees of CCMC's New World Symposium 2019 drew encouragement from the US Surgeon General.

Vice Admiral Jerome Adams, MD, MPH, US Surgeon General

> You have to experience the atmosphere and the camaraderie.

1. Substance abuse issues including the rapid upswing in the use of marijuana without evidence-based protocols and the opioid epidemic
2. Community health as it relates to economic health
3. The nation's health, which affects the nation's safety and security (70% of those who wish to serve are ineligible for military service because of health)

In terms of the opioid epidemic, Dr Adams said that case managers should focus on what each of us can do to address the problems of the 21.1 million Americans with opioid use disorders. Academia, media, companies, faith communities, healthcare professionals, and individual Americans all have a role to play in fighting this epidemic by working to reduce stigma, by promoting diversion programs, by effectively treating those in pain to prevent transitioning to heroin or fentanyl, by carrying naloxone, and by stopping

Attendees and exhibitors discuss needs and solutions in the exhibit hall.

Robert Pearl, MD, author of **The Future of American Healthcare,** *interacts with the CCM audience.*

ensure development of a well-prepared case manager workforce; pay it forward; help develop the next generation of leaders; and improve overall job satisfaction for all.

The ideal mentor is supportive, nurturing, protective, honest with feedback, and understands boundaries, said LeDoux. Mentors should create a stress-free environment so that the mentee can grow. She told the audience, "Share stories, teach, inspire, motivate, and empower. And remember that mentoring is a reflection of who we are."

Next on the agenda was a presentation by Vice Admiral Jerome M. Adams, MD, MPH, US Surgeon General whose motto is "Better Help Through Better Partnerships." Dr Adams began by saying that as Surgeon General he represents the nation's patients, not just the nation's doctors.

He emphasized that case managers must reach people where they are. This means they should use their voices in the community. He believes he is more impactful communicating with the community through social media. The Surgeon General focuses on the following issues in this administration:

> It's very conducive to learning. The speakers are of higher quality than at other events that I've been to.

"Office Hours" attracted attendees who wanted to exchange information and questions on a variety of pressing topics.

misinformation about the problem in part by reading *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016.*

In his experience, what resonates with the community is linking health to prosperity. Case managers must incorporate health equity in all their actions to reduce the rise in health disparities that affect socioeconomics. They should seek out the homeless, collaborate with the military to create community fitness programs, and speak out against e-cigarettes that are affecting education. "Act as one person connected to one family at a time," he stressed. Think of new ways of promoting health: for example, promote a health program in schools as one that will improve academics. As Dr Adams ended his presentation, a rapt audience named him the "Rock Star Surgeon General."

Other session presenters echoed Dr Adams with presentations entitled "Becoming a Culturally Competent Provider of Brain Injury Rehabilitation Service" by Carlos Marquez de la Plata, PhD; "Nurse-Community Navigator Partnerships to Improve Treatment Decision-Making for Patients and Decision Partners" by Jennifer Wenzel, PhD, RN, CCM, FAAN; and "Coordination Closer to Home: Case Management Without Walls," by Julie Schilz, BSN, MBA.

Robert Pearl, MD, best-selling author of The Future of American Healthcare, discussed opportunities to increase quality and lower costs by changing the structure, technology, and leadership of American health care. Dr Pearl said that context dominates what we do, not science and information. Creating the most efficient context requires that (1) we integrate care horizontally and vertically, (2) insist on payment for value not volume, (3) ensure that technology we use addresses a problem, and (4) create a leadership structure.

Wendy Lynch, PhD, presented the topic "Getting to What Matters: Communication Skills Supporting Ethics in Case Management" in which she stated that our reliance on technology and text diminishes connection, satisfaction, and more among our patients. She encouraged the attendees to listen well to patients and get to what they really want. An ability to listen is at the core of ethics in all that case managers do and warned that it's malpractice to tell the patient what you want without knowing what the patient wants.

Meanwhile in the exhibit hall, exhibitors and attendees were getting well acquainted and trading needs and solutions to increase the quality of health care. An exciting part of the exhibit hall was the poster presentations. Shona Metcalf, CCM, from the Carolinas Medical Center, won first place for her poster titled "Bundle Payments Are Here to Stay." Honorable mention went to Kristine Rovell, MSN, RNC, CCM, of Hackensack Meridian Health, Riverview Medical Center, for "ED Care Coordination: Creative Collaboration."

An innovative offering at the Symposium was "Office Hours," in which attendees were encouraged to connect with fellow case managers on a variety of pressing topics. Among these topics were "Catastrophic Case Management" led by Michelle Baker, BS, RN, CRRN, CCM; "Geriatric Care," led by Nina Mottern, RN, BSN, CCM; "Mental Health" led by Jared Young, PsyD, LCSW, CCM, CADC; "Palliative Care" led by Michael Demoratz, PhD, LCSW, CCM; and "Worker's Compensation" led by Chikita Mann, MSN, RN, CCM.

> **"It's valuable to me as a case manager. It keeps me on the cutting edge of case management."**

To wrap up the symposium, CCMC announced next year's date and location: March 12–14, 2020, in Colorado. View more about the 2019 symposium here where you can listen to speaker podcasts and view the exhibitor list. CM

Ready, Set, Transition: Navigating Value-Based Care Initiatives Through Effective Post-Acute Care Transitions

At the CCMC New World Symposium that took place from February 28, 2019, to March 2, 2019, Lecia Snell-Kinen, APRN-CNS, Care Transition Director for Option Care, presented a satellite symposium in which she called transitional care a "whole new type of care."

Better transitions of care are needed to address 2 significant market changes affecting healthcare systems today: (1) the move to alternative payment models that will tie 50% of all Medicare reimbursements to quality and value and (2) financial penalties for readmissions and hospital-acquired conditions related to poor patient outcomes.

Considering Market Forces

Even those working in hospitals that have not signed a value-based contract or a risk contract should be considering the following in their care plans:

- Costs of self-funded insurance for patients
- Large amounts of unpaid charity care
- Provider-owned health plans with Medicare Advantage patients and Medicare "fixed fee" inpatient care
- Commercial payer contracts with incentive programs based on utilization, cost savings, and/or outcomes
- Current diagnosis-related group Medicare payment structure

Poor transitions of care accounts for one-third of readmissions. "As case managers, we need to become more efficient," said Snell-Kinen. "Transitions of care are the 'low-hanging fruit' to improve cost effectiveness and value," continued Snell-Kinen. Unfortunately, only 31% of hospitals surveyed by Avalere Health report having found solutions to patient care after hospital discharge.[1]

According to Snell-Kinen, there are true transitional care services that are reimbursable. She contrasted care delivery and care management in which the latter, according to the National Institutes of Health, is the "deliberate organization of patient care activities between 2 or more participants (including the patient) involved in a patient's care."[2] And these services can be reimbursable when a deliberate process is established.

Variations Are the Enemy

Variations in processes are the true enemies of successful transitional care. Establishing processes with assigned accountability agreed upon by stakeholders and organizational leadership must be part of the solution to combat overestimation of system capabilities, failure to engage key stakeholders, lack of understanding of what partners need, and untimely identification of high-risk patients. To build solutions, 3 goals must be met:

1. Creation of a post-acute care network
2. Identification of high-risk patients
3. Development of transition strategies

Some of the methods to meet these goals include utilization of post-acute care services, development of healthcare partnerships across the care continuum, creation of case management and discharge planning strategies, honing transition processes and accountabilities, and ensuring timely hand-off and availability of patient information across the continuum.

In general, said Snell-Kinen, post-acute services are not well understood or integrated into acute care plans and healthcare delivery. At best, post-acute care "network management" means a provider rotation schedule, often driven by personal relationships and clinical outcomes. Mandatory standardized assessments and outcomes reporting are lacking. And information technology systems of post-acute care providers are not easily integrated with physicians and hospitals. Yet, improvement is possible.

Case managers and their hospital organizations must adopt these tasks and services to improve transitional care:

- Identify high-risk patients
- Manage medication
- Plan transitions
- Engage and educate patients and families
- Transfer the needed information
- Provide follow-up care
- Engage healthcare providers
- Share accountability across providers and organizations

And finally, Snell-Kinen noted, case managers should develop a discharge transition checklist that includes:

- Motivational interviewing
- Identifying primary caregiver
- Reconciling medications
- Educating patients using feedback
- Ensuring patients have medications or prescriptions to fill
- Scheduling actionable diagnostic testing and laboratory tests
- Communicating with primary care physicians/specialists
- Standardized consistent handoff to all post-acute care providers
- Ensuring patients/caregivers know when and whom to call CM

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Continuous Glucose Monitoring: Complete Care Management Solution for Diabetes

During the CCMC New World Symposium that took place from February 28, 2019, to March 2, 2019, Nicholas B. Argento, MD, FACE, Diabetes Technology Director of Maryland Endocrine in Columbia, Maryland, presented a satellite breakfast symposium on continuous glucose monitoring (CGM) that was sponsored by Dexcom.

Dr. Argento reminded the audience of case managers that diabetes care is associated with poor adherence and control among many patients with diabetes (3 in 4 patients).[1] Because of this, patients with type 1 and 2 diabetes do not reach A1C target levels of <7%.[2,3] Also, hypoglycemia is a barrier to achieving tighter glucose control and occurs frequently. Approximately 85% of patients with type 1 diabetes and 44% of insulin-requiring type 2 diabetes experience at least 1 hypoglycemic event every 30 days.[4] What's more, severe hypoglycemia is responsible for 4%-10% of deaths in patients with type 1 diabetes and higher mortality among those with type 2 diabetes.[5,6]

Limitations of self-monitoring blood glucose (SMBG) for treatment decisions are measurements at a single point in time, no indication of direction or speed of changing glucose levels, inability to predict impending hypoglycemia, and a potential for undetected hypoglycemia.[7]

A Behavior Modification Device

The potential of CGM is that it aids in behavior modification for patients with diabetes. The devices are a safety net for hypoglycemia because they send alerts about what will likely happen in the next 30 to 90 minutes, which gives patients important data to inform their treatment.

There are currently two types of CGM: real-time CGM (rtCGM) and intermittently scanned CGM (isCGM). With rtCGM, sensor data is transmitted continuously to a receiver or display device that allows alerts and alarms to be sent to the patient.[8] The alternative, isCGM, does not transmit continuously. Results are available only when the sensor is scanned with a reading device. By scanning at least every 8 hours, full 24-hour data can be captured and downloaded.

Patient Selection

rtCGM is particularly beneficial for patients who have hypoglycemia at night, those who are unaware when they are hypoglycemic, and those who have frequent and severe variations in hypoglycemia. It also works well for patients who need tighter glucose control, have high A1C levels, are physically active and lead busy lifestyles, or cannot achieve adequate glucose control with isCGM. isCGM works well for patients who are newly diagnosed with type 2 diabetes, who are not treated with insulin, have good control but would like to avoid fingersticks, are motivated to scan their device, and have a low or no risk of hypoglycemia.[9]

Currently available standalone CGM devices include Abbott's Freestyle Libre, Dexcom's G6,® Medtronic's Guardian™ Connect, and Senseonics™/Eversense.® Only Medtronic and Dexcom devices allow remote monitoring/data sharing and have smartphone and watch connectivity. Dexcom's device is indicated for children 2 years and older, whereas the other devices are approved for use in those 14 years and older. Built-in audible alerts and alarms are available on Dexcom, Medtronic, and Senseonics/Eversense devices.

Clinical evidence and professional societies indicate that CGM is the standard of care. Remote monitoring can improve the quality of life and peace of mind for patients, parents, and other caregivers, stated Dr. Argento. And finally, cost modeling illustrates potential savings with CGM for diabetes monitoring. CM

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CE 1

The Opioid Crisis: History, Controversies, and Potential Solutions in the Evidence

Doug Kalunian, MD, DFAPA, and **Laurent Tao, MD, MPH, FACP**

The opioid crisis continues to plague the US healthcare system. Its effects are taking a significant toll on the population as seen in the massive loss of life, strains on limited financial resources, and confusion around recent guidelines for prescribing opioids. To better understand the issue, this article will discuss the origins of the crisis, the recent controversies around prescription guidance, and tools that are currently available for both health care providers and case managers.

Retrospective on the National Crisis

The consensus opinion is that the current opioid crisis began in the 1980s and stemmed from many factors. In 1980, *The New England Journal of Medicine* published a 5-sentence "Letter to the Editor" in which the authors discussed their experience with acute opioid therapy in a monitored, hospital-based setting and stated that "despite widespread use of narcotics in hospitals, the development of addiction is rare in medical patients with no history of addiction."[1] This text was pivotal, as the publication would eventually be cited several hundred times in the following years,[2] including a landmark consensus document published by the American Pain Society and the American Academy of Pain Medicine that promoted aggressive pain control. Both organizations advised that there was minimal risk of patients developing addiction or overdosing when receiving chronic opioid therapy for pain.[3] Remarkably, in 2017 *The New England Journal of Medicine* appended a new Editor's Note to this letter, which adds "for reasons of public health, readers should be aware that this letter has been 'heavily and uncritically cited' as evidence that addiction is rare with opioid therapy."

By the 1990s, the pharmaceutical industry was aggressively marketing opioids. When a sustained-release oxycodone painkiller called OxyContin® was approved by the U.S. Food and Drug Administration (FDA) in 1995, it was accompanied by a "starter coupon program" from the drug manufacturer that offered patients a free prescription for a supply that could last anywhere from 7 to 30 days. However, patients weren't the only target of such campaigns; health care providers were also singled out by marketing efforts that included branded fishing hats, plush toys, and music CDs. According to the Drug Enforcement Administration (DEA), this use of promotional items to market OxyContin® was unprecedented among schedule II opioids.[4]

A subsequent report from the DEA in November 2003 noted that an "educational" video for physicians created by the drug's manufacturer included a claim that opioid analgesics cause addiction in <1% of patients. The DEA Chief Inspector found this assertion to be unsubstantiated and misleading to prescribers. Although it is difficult to measure the exact impact these questionable marketing tactics had on increasing the use of OxyContin®, prescriptions of the drug accelerated from 670,000 to approximately 6.2 million between 1997 and 2002.[4]

During the same period, prescribing (grams/per 100,000 population) also increased for other opioid medications including fentanyl (+226%), morphine (+73%), and oxycodone (+402% increase). The widespread use of these drugs set off proverbial fire alarms with the Drug Abuse Warning Network, which reported that mentions for these specific drugs were becoming widespread in hospital emergency departments with fentanyl (+641%) seeing the

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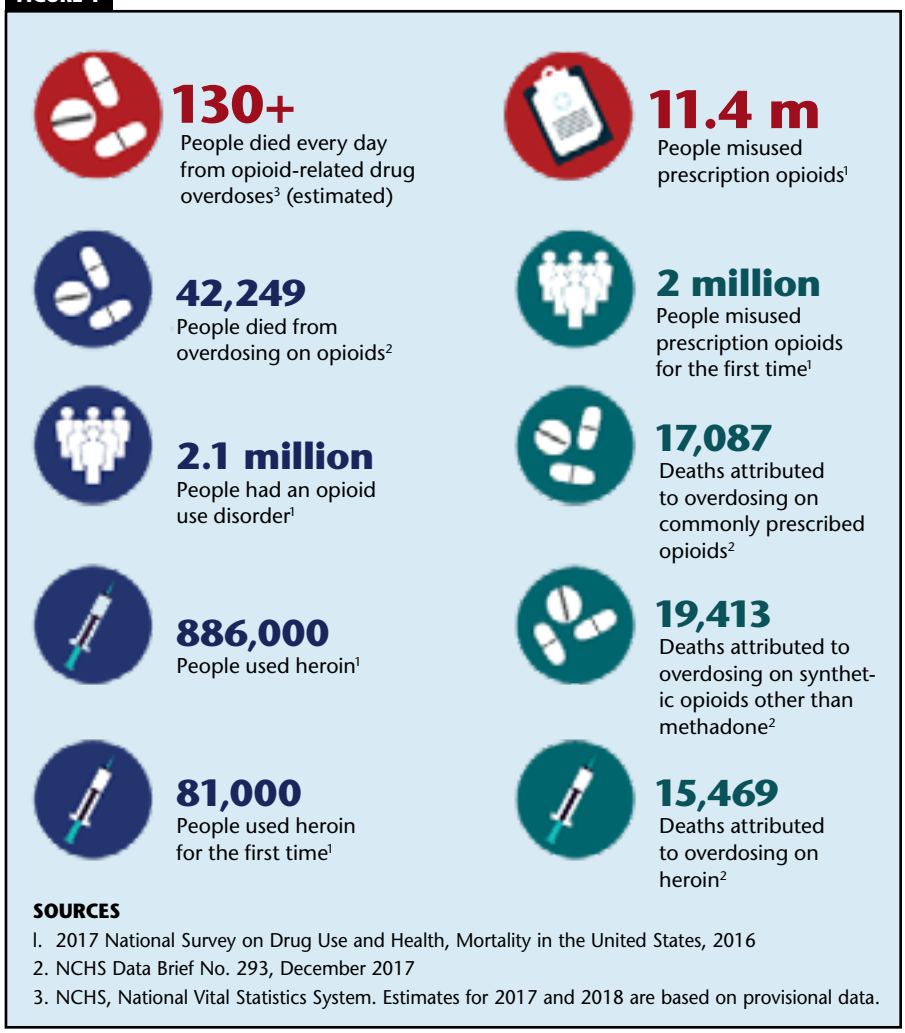
Between 1999 and 2017, nearly 400,000 people died from overdoses related to both prescribed and nonprescribed opioids.

FIGURE 1 THE OPIOID EPIDEMIC BY THE NUMBERS: 2016 AND 2017 DATA



Source: https://www.hhs.gov/opioids/sites/default/files/2018-09/opioids-infographic.pdf

largest increase in mentions, followed by morphine (+113%) and oxycodone (+402%).[5]

Despite these clear warning signs, the number of lives claimed by opioid overdoses (including those from illicit use) has continued to be staggering. Between 1999 and 2017, nearly 400,000 people died from overdoses related to both prescribed and nonprescribed opioids.[6] In 2017, approximately 11.4 million people misused opioids, and among those individuals aged 12 or older who misused opioid pain medications, about half (53.1%) obtained it from a friend or relative (Figure 1).[7]

The Government Response

In 2003, as part of the U.S. Department of Justice–Bureau of Justice Assistance's Comprehensive Opioid Abuse Site-based Program, grants from the Harold Rogers Prescription Drug Monitoring Program provided funds to plan, implement, and enhance prescription drug monitoring programs (PDMPs). Some of the goals of this program were to expand diversion and alternatives to incarceration programs, to expand the availability of treatment and recovery support services in rural or tribal communities, and to implement and enhance PDMPs.[8]

In 2005, President George W. Bush signed into law the National All Schedules Prescription Electronic Reporting Act (NASPER), which authorizes the U.S. Department of Health and Human Services (HHS) to award grants to states to construct and enhance existing PDMPs, thus providing for the further establishment of State Controlled Drug Monitoring Programs. While these programs have contributed to the reduction in opioid prescriptions, deaths by opioid overdose have continued to escalate at alarming rates.[9]

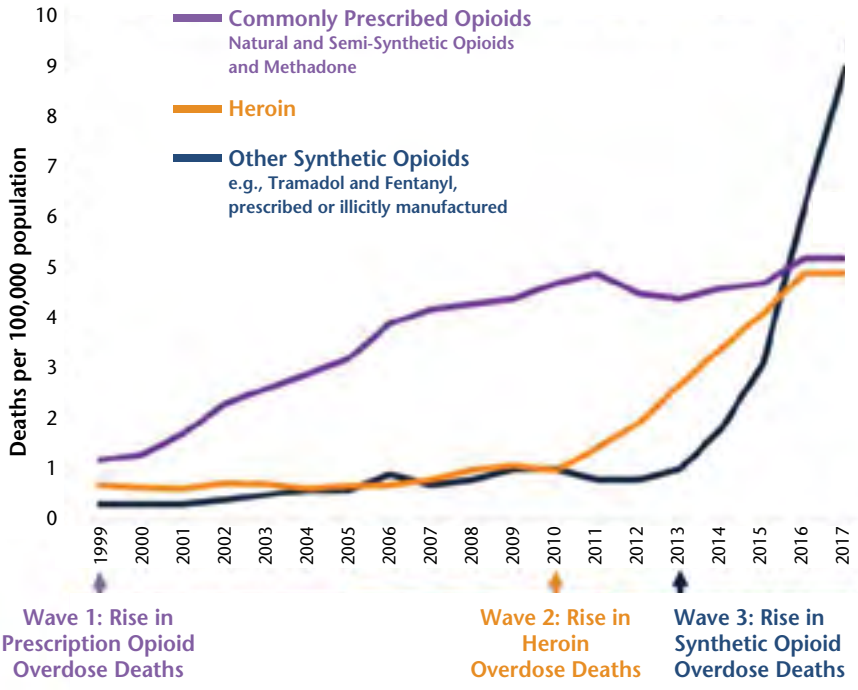
In 2015, the DEA and the Centers for Disease Control and Prevention (CDC) issued nationwide alerts identifying illicitly manufactured fentanyl as a threat to public health and safety. In response, the Secretary of Health and Human Services launched an initiative to reduce opioid misuse, abuse,

FIGURE 2 **3 WAVES OF THE RISE IN OPIOID OVERDOSE DEATHS**

From 1999–2017, almost 400,000 people died from an overdose involving any opioid, including prescription and illicit opioids.[2]

This rise in opioid overdose deaths can be outlined in three distinct waves.

1. The first wave began with increased prescribing of opioids in the 1990s[3], with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999.
2. The second wave began in 2010, with rapid increases in overdose deaths involving heroin.
3. The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids—particularly those involving illicitly-manufactured fentanyl (IMF). The IMF market continues to change, and IMF can be found in combination with heroin, counterfeit pills, and cocaine. [2,4]



Source: https://www.cdc.gov/drugoverdose/epidemic/index.html

SOURCE: National Vital Statistics System Mortality File

and overdose by expanding medication-assisted treatment, increasing the availability and use of naloxone, and promoting safer opioid prescribing.[10]

In 2016, the CDC published a guideline for prescribing opioids for treatment of chronic pain.[11] In addition, the U.S. Surgeon General sent a personal letter to over 2.3 million health care practitioners and public health leaders across the country, launching the "Turn the Tide Rx" campaign and asking prescribers to pledge to "turn the tide on the opioid crisis" by:

- Educating themselves to treat pain safely and effectively
- Screening patients for opioid use disorder and providing or connecting them with evidence-based treatment
- Shaping how the rest of the country sees addiction by talking about and treating it as a chronic illness, not a moral failing[12]

Acknowledging the seriousness of the crisis, HHS declared the opioid epidemic a public health emergency in 2017 and announced a 5-point strategy to combat the opioid crisis, which included:[9,13]

- Improving access to treatment and recovery services
- Promoting use of overdose-reversing drugs
- Strengthening our understanding of the epidemic through better public health surveillance
- Providing support for cutting-edge research on pain and addiction
- Advancing better practices for pain management

By 2016 and 2017, reports showed that 2.1 million people in the United States had an opioid use disorder. In 2017 alone, there were over 47,000 deaths due to opioid overdose. This was more than any previous year on record, and it is estimated that 36% to 40% of the opioid overdose deaths involved a prescription opioid. The rate of opioid-related deaths continues to climb, with no end or reversal in sight (Figure 2).[6,14,15]

Appropriate Use of Opioids and Evidence-Based Guidelines

The path to an opioid use disorder often begins with prescribed opioids for the treatment of pain. Opioids have been commonly prescribed for pain relief due to many factors. Short-acting opioids (e.g., immediate-release morphine, codeine, fentanyl, hydrocodone, and oxycodone) are associated with a rapid increase and decrease in blood levels, so the therapeutic response is relatively rapid. They are also effective medications for the treatment of pain. In 2001, the Joint Commission rolled out its Pain Management Standards, which asked providers to consider pain as a "fifth vital sign" and to treat

pain as needed. It is now apparent that ongoing screening and monitoring is needed to assess patients for opioid treatment efficacy, safety, misuse, abuse, and diversion.

The CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016[16] was written primarily for an audience of primary care clinicians who treat patients with chronic pain in outpatient settings. The authors report that prescriptions by primary care clinicians account for nearly half of all opioid prescriptions dispensed, and the growth in prescribing rates among these clinicians has been above average. The guideline is intended to inform clinicians who are considering prescribing opioid pain medications for painful conditions that may or have already become chronic.[16]

The CDC was the first federal agency to provide practical recommendations to primary care clinicians regarding the role of prescription opioids for chronic pain that is not related to cancer pain, end-of-life, or palliative care. The guideline was developed using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework. Recommendations were made based on a systematic review of scientific evidence while also considering benefits and harms, values and preferences, and resource allocation. In addition, the CDC included input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee, adding to the strength of the recommendations.[11]

The authors of the guideline state: "It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, to improve the safety and effectiveness of pain treatment, and to reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death."[16]

The CDC Guideline presents 12 recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care. The recommendations are organized in 3 sections, as follows:[11,17]

- Determination of when to initiate or continue opioids for chronic pain: Nonpharmacologic therapy and nonopioid pharmacologic

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therapy are the preferred treatment strategies for chronic pain and should be combined with opioids, if opioid treatment is prescribed. Opioid therapy should be considered only if the benefits for pain and function outweigh the risks. Once started, opioid therapy should be continued only if there is clinically meaningful improvement in pain and function, which outweigh risks. Risks, benefits, and patient and provider responsibilities should be discussed with the patient.

- Opioid selection, dosage, duration, follow-up, and discontinuation: When initiating opioid therapy, instead of starting with extended-release/long-acting opioids, immediate-release opioids should be prescribed, and they should be prescribed at the lowest effective dose. Caution should be taken when prescribing opioids at any dosage, and clinicians should reassess benefits vs risks within 1 to 4 weeks of starting opioid therapy or dose escalation, and every 3 months or less for ongoing treatment. Reassessment was also recommended when increasing dosage to 50 or more morphine milligram equivalents (MME) per day. When opioids are prescribed for acute pain, immediate-release opioids should be prescribed for a duration no greater than needed for the expected duration of the patient's severe pain requiring opioids. A guideline of a prescription for 3 days or less was noted as often sufficient, and more than 7 days would rarely be needed.
- Assessment of risk and addressing harms of opioid use: The patient's history of controlled substance prescription use (using state PDMP data) should be reviewed when initiating opioid therapy and periodically during ongoing therapy to determine risk for overdose. The CDC recommended urine drug testing before initiating treatment and at least annually during ongoing opioid treatment. Concurrent use of benzodiazepines and opioids was recommended to be avoided whenever possible.

The Guideline Controversy

Treatment of pain is a complex therapeutic dilemma, as there are limited therapeutic options for the treatment of severe pain. Given that pain is a subjective phenomenon, defining and classifying the severity of pain makes treatment even more challenging.

Despite attempts to provide evidence-based recommendations to aid physicians with prescribing opioid medications to manage their patients' pain, the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain[12] has been controversial. Concerns include potential misinterpretation of the recommendations with resultant underprescribing and decreased reliance on clinical judgment in prescription decision-making, lack of access to opioid medications despite appropriate clinical need, and shifting of decision-making from the prescribers who perform clinical assessments of need to pharmacy benefit management programs.

In November 2018, the American Medical Association (AMA) House of Delegates published Resolution 235–Inappropriate Use of CDC Guidelines for Prescribing Opioids. The resolution addresses physician concerns that although the CDC Guideline recommendations were developed with good intentions, they assert that the guidelines have been misinterpreted or applied in inappropriate manners by legislators, regulators, and law enforcement agencies and that they have been adopted by insurers and pharmacies without adequate provisions for clinical input. The AMA asserts that despite the CDC's attempt to make a positive impact on the use, misuse, potential risks, and documented potential lethal impact of opioids, the recommendations have also resulted in interference in providers' management of their patients' severe pain.[18]

The AMA's resolution took the following actions:[17]

- Applauded the CDC for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths
- Resolved that the AMA will actively continue to communicate and engage with pharmacy chains,

With the appropriate interpretation and administration of the CDC guidelines and with the use of additional evidence-based tools such as the Diagnosis, Intractability, Risk, Efficacy (DIRE) tool and the Opioid Risk Tool (ORT), providers can identify candidates for opioid treatment who have lower risks of developing an opioid use disorder.

pharmacy benefit managers, National Association of Insurance Commissioners, Federation of State Medical Boards, and National Association of Boards of Pharmacy, opposing blanket proscriptions against filling prescriptions for opioids that exceed numerical thresholds without consideration of the patient's diagnosis, previous response to treatment, and other clinical issues that would support the prescription within standards of good quality patient care

- Affirmed that some patients with acute or chronic pain can benefit from taking opioid pain medications at doses greater than generally recommended in the CDC Guideline and that such care may be medically necessary and appropriate
- Advocated against misapplication of the CDC guideline by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies with resultant prevention or limitations of patients' medical access to opioid analgesic treatment
- Advocated against the use of MME thresholds as anything more than guidance and stated that physicians should not be subject to professional discipline, criminal prosecution, civil liability, or other penalties or practice limitations solely due to prescribing opioids above the MME guidelines documented in the CDC Guideline for Prescribing Opioids

Potential Solutions in the Evidence for Physicians, Nurses, and Case Managers

Evidence-based guidelines, along with legislative efforts, remain key strategies to address the opioid crisis in the United States. Since the publication of the CDC's guideline, there have been reports that the pendulum has swung and that opioid prescriptions have decreased; the opioid crisis has, however, persisted, with a continued climb in opioid overdose deaths. This prompted a backlash over the guideline, with concerns that the sole goal of the guideline was to limit opioid prescriptions and that patients who legitimately required opioid medications turned to illicit drugs for relief and died from overdose due to differences in strengths of prescribed vs illicit opioids.

However, it is important to find a middle ground and recognize that evidence-based care can still play a crucial role in turning around this crisis. With the appropriate interpretation and administration of the CDC guidelines and with the use of additional evidence-based tools such as the Diagnosis, Intractability, Risk, Efficacy (DIRE) tool and the Opioid Risk Tool (ORT), providers can identify candidates for opioid treatment who have lower risks of developing an opioid use disorder. These same tools can help identify patients at higher risk of opioid dependence and prompt providers to steer these patients away from illicit drugs, instead addressing their pain conditions with an appropriate, closely managed treatment plan. Patients can also be steered toward substance use disorder treatment when the need is identified, particularly as access to these programs increases.

For many years, MCG Health, part of the Hearst Health network, has been offering evidence-based guidelines and software tools to support health care professionals tackling the opioid crisis. MCG can help both providers and health plans manage patients with chronic cancer-related pain, non-cancer-related pain, and those who need palliative/end-of-life care by offering guidance on non-pharmacologic strategies for pain control, as well as on the appropriate of use of long-acting opioids. In addition, the MCG Behavioral Health Care solution can assist with the treatment of patients who struggle with opioid dependence and withdrawal, as it contains guidelines on Medication-Assisted Treatment and medications such as extended-release injection formulations of buprenorphine and naltrexone, buprenorphine implants, and buprenorphine-naloxone. These guidelines contain built-in tools such as the aforementioned DIRE tool and the COWS (Clinical Opiate Withdrawal Scale) calculator, which helps to identify patients who require treatment for opioid withdrawal.

Consistent application of evidence-based guidance across the entire continuum of care is essential to ensure

that patients at risk for or who suffer from substance-related disorders have access to the resources that they need. For example, the MCG Chronic Care content contains assessments that case managers may use to identify problems, goals, and interventions, as well as barriers to care, for patients with substance-related disorders. In addition, assessments on topics such as Narcotic/Opioid Misuse, pain medication use, and various social determinants of health can help to synthesize a plan of care that is targeted to a patient's specific situation and needs. Finally, patient education materials for substance-related disorders can help patients to learn how to self-manage their condition and feel more empowered when engaging with various members of the care team.

In conclusion, when used properly, evidence-based guidelines can help to re-center the opioid-prescribing pendulum, while also turning the tide on the opioid crisis. **CE 1**

For readers who may be interested, MCG recently hosted a webinar on this topic and you may view it on-demand here.

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Approved for 2 hours ethics credit

CE II

Ethical Considerations for Care Coordination for Clients with Mental Illness

Chikita Mann, MSN, RN, CCM

Mental health has gained much attention in the past 10 years for several reasons. One reason is because celebrities have been vocal about their mental health struggles. Carrie Fisher (best known as Princess Leia in Star Wars) battled bipolar disorder. Dwayne "The Rock" Johnson admitted to bouts with depression. Demi Lovato wrote a song "Sober" detailing her struggles with substance abuse and bipolar disorder. Michelle Williams (Destiny's Child) spoke of her struggles with depression on her reality show. Several artists collaborated on a song called "1-800-273-8255," a national suicide prevention hotline. The director of the National Suicide Prevention Lifeline stated that they experienced the second highest volume of calls on the day this song was released. Sadly we have lost beloved celebrities to suicide (Robin Williams had bipolar disorder and Kate Spade had depression), which cast a spotlight on mental health disorders.

The changing subcultures within our population are another reason. The millennial generation has been pivotal in increasing mental health awareness, and yet it is considered the anxious generation. With millennials comprising more than 30% of the current workforce, workplace mental health has become a priority.[1] Our aging population is another subculture within our population that requires unique attention as it relates to mental health. We are currently experiencing the "Silver Tsumani" in which the population of individuals aged 65 and over in the US has passed 50 million for the first time in history and is projected to reach over 70 million in the next 25 years.[2] The Institute of Medicine (IOM) has projected there will be approximately 10.1 to 14.4 million Americans aged 65 and older who will have mental health or substance abuse disorders.[3] The mental health of older Americans has been identified as a public health concern according to the Centers for Disease Control and Prevention. This population has an increased risk of developing depression and anxiety due to loss of loved ones, dealing with more than one chronic illness, retirement, and/or other stressful events.[4]

Another subculture within our population who are getting more attention as it relates to mental illness are Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) individuals. Research has shown that LGBTQ individuals are 3 times more likely to experience depression, generalized anxiety, and substance abuse. Reasons include fear of disclosing their sexual orientation and enduring stigma and discrimination.[5] Higher rates of poverty and unemployment are common with transgender individuals, which may cause them to have less access to health insurance.

Another subculture in our society is veterans, and the number of veterans is increasing. In 2016, according to the Department of Veterans Affairs, there were around 20.4 million US veterans, most of whom were from the Gulf War era. The RAND Center for Military Health Policy reported that 20% of veterans who served in either Iraq or Afghanistan had either posttraumatic stress disorder or major depression. At least half of these veterans had traumatic brain injury (TBI). A more sobering fact is that veterans also have an increased risk of suffering from substance abuse disorder.[6]

A third reason for increased attention to mental health is because of the cultural diversity of our population. It is projected that by 2044, more than half of all Americans will belong to a minority group.[7] Diverse communities face obstacles such as increased levels of stigma, lack of health insurance, distrust in the health care system, inaccurate information about mental health, and language barriers. Mental health disparities usually occur due to prejudice, lack of cultural competence, and insufficient access to mental health services. Ethnic/racial minority youth who have behavioral health issues are usually referred to the juvenile justice system rather than behavioral health centers.[8]

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Mental health disorders cost the global economy $1 trillion in lost productivity a year.
–World Health Organization

Overview of Four Widely Known Mental Illnesses

Depression is called major depressive disorder (MDD) or clinical depression. More than 16.1 million US adults are affected by MDD. It is defined as a mood disorder characterized by persistent loss of interest and feeling of sadness. It can affect how one thinks, feels, or behaves and lead to emotional and physical problems. These symptoms can be severe enough to cause problems with day-to-day activities. Factors that can contribute to the development of depression include brain chemistry, biological differences, changes in the body's proportion of hormones, and inherited traits. Individuals with chronic illness may develop depression as a psychological response to receiving the diagnosis as well as dealing with discomfort and impairment caused by the illness.[9]

Anxiety disorders affect over 40 million adults. They are among the most common mental illnesses in America. The main five kinds of anxiety disorders are generalized anxiety disorders (GAD), obsessive-compulsive disorder (OCD), panic disorder, phobias, posttraumatic disorder, and social anxiety disorder. However, these 5 anxiety disorders have a commonality: endless, excessive despair and worry in nonthreatening situations. Frequently, individuals with 1 anxiety disorder will have another concurrent anxiety disorder. Individuals with an anxiety disorder are also likely to be depressed or to deal with substance misuse.[10]

Bipolar disorder is defined by severe shifts in mood and energy. According to the World Health Organization (WHO), it is the sixth leading cause of disability in the world. It is posited that there is a familial component to bipolar disorder because more than two-thirds of individuals with bipolar disorder have a close relative with the disorder. Bipolar disorder is unique in that the symptoms fall into two classifications: mania and depression. It can also be broken down into bipolar I and II disorders.[11,12]

Substance use disorder, which is sometimes referred to as drug addiction, is defined as a lack of ability to appropriately control the use of legal or illegal substances.[13] It can affect an individual's mood and behavior. Substance use disorder is included in this article because research has shown high rates of comorbid substance use with anxiety disorders as well as with depression and bipolar disorders. There are 3 main reasons for this. The first reason is that genetics, environmental factors, brain circuitry, and neurotransmitter involvement as well as stress and trauma can all contribute to coexisting mental illness and substance abuse. The second reason why mental illness and substance abuse usually coexist is that an individual with moderate-to-severe mental illness may use drugs to self-medicate. The third reason is that substance use can alter the brain in ways that predispose individuals to develop mental illness.[14]

Ethical Considerations with Mental Illness

There are often unique ethical dilemmas when treating clients with mental illness. In this section, we will discuss the role of stigmatization in ethical behavior. We will also address the complicated privacy and confidentiality issues associated with individuals with mental illness.

The Role of Stigma

Per WHO, mental health stigma is a global public health and social injustice issue. Being an advocate for an individual with mental illness requires the board-certified case manager/disability specialist to recognize the presence of public stigma towards individuals with mental illness and the client's self-stigma. Stigma is defined as established negative opinions that persuade individuals to shun and stay away from a particular population.[15,16] Stigma sets the foundation for prejudice and biases, with discrimination and exclusion being the final (and damaging) results.[17] Those with mental illness are unfortunately perceived as being erratic and threatening. This mindset can have far-reaching consequences for individuals with mental illness. Individuals with mental illness are at increased risk of experiencing housing and employment discrimination. Stigmatizing beliefs can lead to the individual's mental capacity being determined as inadequate, which can affect quality decisions concerning their treatment.[16]

The client's self-stigma involves the individual being aware of negative beliefs about individuals with mental illness. Over time, the client begins to internalize these negative beliefs and apply these negative beliefs to themselves. This evolves into the individual having low self-esteem and feelings of incompetence. Their ability to effectively socialize with others is affected tremendously. Individuals with self-stigma may not seek appropriate and necessary mental health

treatment. This self-stigma can extend to the individual not putting effort into seeking gainful employment because of the perception that they are not worthy of or capable of keeping a job. The client may not seek necessary treatment to prevent label avoidance and may not want to be seen seeking mental health services.[17]

Several studies have demonstrated that even health professionals can have stigmatized beliefs toward individuals with mental illness. According to both Commission for Case Manager Certification (CCMC) and Certified Disability Management Specialist (CDMS) Professional Codes of Conduct, the board-certified case manager/disability specialist is mandated to not participate in any discriminatory actions towards a client. Stigma has been cited as a pivotal obstacle to effective patient engagement. It can also deter advocacy for mental well-being. Research performed on stigma and mental illness shows that health professionals with stigmatized beliefs may not offer appropriate mental health services and resources to individuals with mental illness.[15,16] Therefore, board-certified case manager/disability specialists have to ensure that they are aware of potential individual biases and attitudes toward those with mental illness. One primary way to do this is to increase their mental health literacy because this enables the board-certified case manager/disability specialist to be able to function as an informed advocate. Research has shown that improved information about mental health and enhanced understanding of available sources of treatment can assist in early identification of mental disorders and better mental health outcomes.[18]

Another resource for the board-certified case manager/disability specialist in combatting stigma is use of the strength-based approach. This approach is well accepted and well known for success in mental health recovery. This individualized approach focuses on the clients' strength and available resources. The individual's right to autonomy is affirmed and incorporated into the recovery process. This approach ensures that the individual with mental illness progresses towards recovery and self-sufficiency. Elaborating on an individual's strength can play a role in achieving positive psychosocial functioning and increasing the individual's competencies. An additional benefit of focusing on the individual's strength is that it can motivate the individual to seek treatment and use available resources. The strength-based approach provides a basis for the development of a therapeutic relationship between the board-certified case manager/disability specialist and the client.[19]

Acknowledging stigma in mental health is just one part of being an informed advocate. It is imperative that the board-certified case manager/disability specialist

"A diagnosis is burden enough without being burdened by secrecy and shame." –*Jane Pauley*

understand how the principles of beneficence and justice are integral to care coordination for the individual with mental illness. Board-certified case manager/disability specialists have a duty to advocate for their clients' right to access mental health resources. They must additionally understand their role in helping to eradicate the stigma of mental illness by educating those involved in the individual's care, which could include family and employers.

Another ethical component in care coordination for the individual with mental illness is the competence of the board-certified case manager/disability specialist. Both are responsible for only practicing within their education, skill set, and professional practice. The case manager should be proactive in obtaining accurate knowledge and researching available resources. If the case manager does not have a background in counseling, the client should be informed so there is no misunderstanding of the role and capabilities of the board-certified case manager/disability specialist. The board-certified case manager/disability specialist may need to refer the client to the appropriate discipline (ie, licensed professional counselor) or work with their primary care provider to facilitate a referral to the correct discipline.

Privacy, Confidentiality, and Mental Illness

Privacy and confidentiality is often at the center of care coordination for individuals with mental illness. This can be complicated when individuals have periods of impaired decision making and mental capacity. Privacy is an individual's fundamental privilege to decide how much information is shared with others. Confidentiality compels the board-certified case manager/disability specialist to not reveal anything about a client to anyone except under certain circumstances.[20] According to the ethical principle of veracity, the board-certified case manager/disability specialist must be truthful and forthcoming about who will receive information about the client.

The board-certified case manager/disability specialist should be acutely aware of the Health Insurance Portability and Accounting Act's (HIPAA's) differentiation between personal health information and psychotherapy notes. Personal health information includes medication prescriptions and a summary of diagnosis, symptoms, treatment plan, prognosis, and progress. Psychotherapy notes are those that are recorded by a mental health professional in a private session or in a group, family, or joint session. Per HIPAA, release of psychotherapy notes requires the individual's authorization. The authorization must identify who can receive information, what type of information can be disclosed, a description of the objective of the authorization, an expiration date, and the signature of the individual permitting the disclosure. An exception to this is for the originator to use these notes for mental health training and education.[21] Another notable exception with disclosure of information is the "duty to warn and protect" when the client has verbalized an intent to harm a third party.[22]

Because of the potential for discrimination and to avoid embarrassment for the client, the case manager should ask him/herself the following when it comes to sharing information: who needs to know, why do they need to know, and how much do they need to know. In the event that there are dual relationships with the individual, family members, and payer source, this must also be disclosed to the client. To ensure appropriate disclosure of information to the correct entity, the board-certified case manager/disability specialist should secure a signed consent or authorization from the individual. Ask the client if he/she has a psychiatric advance directive that states preferred medical treatment and wishes in the event of a mental health crisis. The directive also designates who can make medical decisions on behalf of the client when a mental health crisis occurs. This provides the client protection from unwanted medical treatment and promotes self-determination and empowerment.[23]

In today's society, social networking and Google is a mainstay. The case manager may receive a friend request from the client. If this happens, it is recommended that board-certified case manager/disability specialist refrain from developing "personal virtual relationships" to preserve appropriate professional boundaries with the client. In addition, any information posted on a social network is not viewed as confidential and can be deemed as discoverable.[24] If a client goes missing or is not returning calls, the case manager may believe it necessary to possibly search social media or Google the individual. This can be seen as a breach of privacy and confidentiality if the client does not know the case manager is doing this. If the case manager decides to perform an online search, he/she should have the client's best interest at heart and assist the board-certified case manager/disability specialist in being an informed advocate for the client.

"The secret of the care of the patient is in caring for the patient." –*Francis Weld Peabody*

In addition to the CCMC and CDMS Codes of Professional Conduct, other sources for dealing with ethical dilemmas are the code of ethics for the health care professional's respective licensing agency. The American Nurses Association (ANA) Code of Ethics is available for nurses. The National Association of Social Workers (NASW) has a code of ethics for social workers.

Conclusion

Our society has become more aware of the prevalence of mental illness via media and because of our population's changing cultural demographic. However, there is much work to be done with addressing stigmatization and discrimination towards individuals with mental illness. As board-certified case manager/disability specialists, we can become a part of the solution by increasing our mental health literacy. Being an informed advocate for individuals with mental illness requires us to be vigilant in adhering to our Codes of Professional Conduct. CE II

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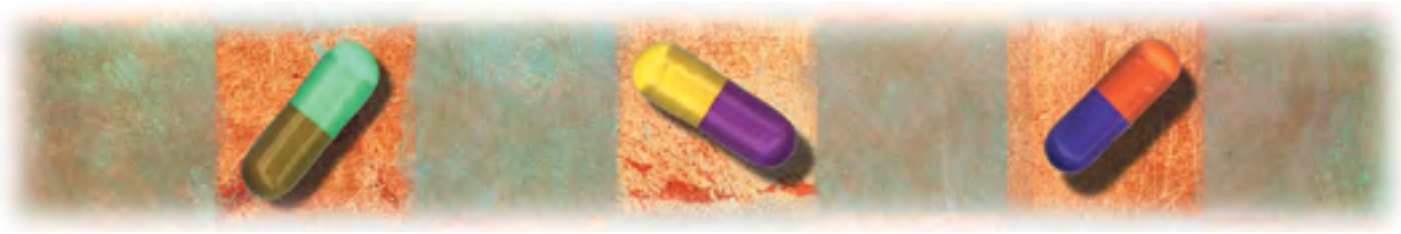

Zulresso™ (brexanolone) injection

INDICATIONS AND USAGE

Zulresso is indicated for the treatment of postpartum depression (PPD) in adults.

DOSAGE AND ADMINISTRATION

Important Considerations Prior to Initiating and During Therapy

A healthcare provider must be available on site to continuously monitor the patient, and intervene as necessary, for the duration of the Zulresso infusion. Monitor patients for hypoxia using continuous pulse oximetry equipped with an alarm. Assess for excessive sedation every 2 hours during planned, non-sleep periods. Initiate Zulresso treatment early enough during the day to allow for recognition of excessive sedation.

Recommended Dosage

Administer Zulresso as a continuous intravenous (IV) infusion over a total of 60 hours (2.5 days) as follows:

- 0 to 4 hours: Initiate with a dosage of 30 mcg/kg/hour
- 4 to 24 hours: Increase dosage to 60 mcg/kg/hour
- 24 to 52 hours: Increase dosage to 90 mcg/kg/hour (a reduction in dosage to 60 mcg/kg/hour may be considered during this time period for patients who do not tolerate 90 mcg/kg/hour)
- 52 to 56 hours: Decrease dosage to 60 mcg/kg/hour
- 56 to 60 hours: Decrease dosage to 30 mcg/kg/hour

If excessive sedation occurs at any time during the infusion, stop the infusion until the symptoms resolve. The infusion may be resumed at the same or lower dose as clinically appropriate.

Preparation and Storage Instructions

Zulresso is supplied in vials as a concentrated solution that requires dilution prior to administration. After dilution, the product can be stored in infusion bags under refrigerated conditions for up to 96 hours. However, given that the diluted product can be used for only 12 hours at room temperature, each 60-hour infusion will require the preparation of at least five infusion bags.

Prepare according to the following steps using aseptic technique:

- Visually inspect the vials of Zulresso for particulate matter and discoloration prior to administration. Zulresso is a clear, colorless solution. Do not use if the solution is discolored or particulate matter is present.
- The 60-hour infusion will generally require the preparation of five infusion bags. Additional bags will be needed for patients weighing ≥ 90 kg.
- For each infusion bag:
  - –Prepare and store in a polyolefin, non-DEHP, nonlatex bag, only. Dilute in the infusion bag immediately after the initial puncture of the drug product vial.
  - –Withdraw 20 mL of Zulresso from the vial and place in the infusion bag. Dilute with 40 mL of Sterile Water for Injection, and further dilute with 40 mL of 0.9% Sodium Chloride Injection (total volume of 100 mL) to achieve a target concentration of 1 mg/mL.
  - –Immediately place the infusion bag under refrigerated conditions until use.

Diluted Zulresso storage instructions:

- If not used immediately after dilution, store under refrigerated conditions for up to 96 hours. Prolonged storage at room temperature may support adventitious microbial growth.
- Each prepared bag of diluted Zulresso may be used for up to 12 hours of infusion time at room temperature. Discard any unused Zulresso after 12 hours of infusion.

Administration Instructions

Zulresso must be diluted before administration. The following are important administration instructions:

- Use a programmable peristaltic infusion pump to ensure accurate delivery of Zulresso.
- Administer Zulresso via a dedicated line. Do not inject other medications into the infusion bag or mix with Zulresso.
- Fully prime infusion administration sets with admixture before inserting into the pump and connecting to the venous catheter.
- Use a PVC, non-DEHP, nonlatex infusion set. Do not use in-line filter infusion sets.

Recommendations in Patients with End Stage Renal Disease
Avoid use of Zulresso in patients with end stage renal disease (ESRD) with eGFR of < 15 mL/minute/1.73 m^2 because of the potential accumulation of the solubilizing agent, betadex sulfobutyl ether sodium.

DOSAGE FORMS AND STRENGTHS
Injection: 100 mg/20 mL (5 mg/mL) clear, colorless solution in a single-dose vial.

CONTRAINDICATIONS
None.

WARNINGS AND PRECAUTIONS

WARNING: EXCESSIVE SEDATION AND SUDDEN LOSS OF CONSCIOUSNESS

Patients treated with Zulresso are at risk of excessive sedation or sudden loss of consciousness during administration. Because of the risk of serious harm, patients must be monitored for excessive sedation and sudden loss of consciousness and have continuous pulse oximetry monitoring. Patients must be accompanied during interactions with their child(ren). Because of these risks, Zulresso is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Zulresso REMS.

Zulresso Risk Evaluation and Mitigation Strategy (REMS)
Zulresso is available only through a restricted program under a REMS called the Zulresso REMS because excessive sedation or sudden loss of consciousness can result in serious harm. Notable requirements of the Zulresso REMS include the following:

- Healthcare facilities must enroll in the program and ensure that Zulresso is only administered to patients who are enrolled in the Zulresso REMS.
- Pharmacies must be certified with the program and must only dispense Zulresso to healthcare facilities who are certified in the Zulresso REMS.
- Patients must be enrolled in the Zulresso REMS prior to administration of Zulresso.
- Wholesalers and distributors must be registered with the program and must only distribute to certified healthcare facilities and pharmacies. Further information, including a list of certified healthcare facilities, is available at www.zulressorems.com or 1-844-472-4379.

ADVERSE REACTIONS
Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

The data described below reflect exposure to Zulresso in 140 patients with postpartum depression (PPD). A titration to a target dosage of 90 mcg/kg/hour was evaluated in 102 patients and a titration to a target dose of 60 mcg/kg/hour was evaluated in 38 patients. Patients were then followed for 4 weeks.

The most common adverse reactions (incidence ≥5% and at least twice the rate of placebo) were sedation/somnolence, dry mouth, loss of consciousness, and flushing/hot flush.

Adverse Reactions Leading to Discontinuation, Dosage Interruption, or Dosage Reduction
In the pooled placebo controlled-studies, the incidence of patients who discontinued due to any adverse reaction was 2% of Zulresso-treated patients compared to 1% of placebo-treated patients. The adverse reactions leading to treatment discontinuation in Zulresso-treated patients were sedation-related (loss of consciousness, vertigo, syncope, and presyncope) or infusion site pain.

In the pooled placebo controlled-studies, the incidence of patients who had an interruption or reduction of the dosage due to any adverse reaction was 7% of Zulresso-treated patients compared to 3% of placebo-treated patients. The adverse reactions leading to dose reduction or interruption in Zulresso-treated patients were sedation-related (loss of consciousness, syncope, somnolence, dizziness, fatigue), infusion site events, changes in blood pressure, or medication error due to infusion pump malfunction. Three Zulresso-treated patients who had a dosage interruption because of loss of consciousness subsequently resumed and completed treatment after resolution of symptoms; two patients who had dosage interruption because of loss of consciousness did not resume the infusion.

DRUG INTERACTIONS
CNS Depressants
Concomitant use of Zulresso with CNS depressants (e.g., opioids, benzodiazepines) may increase the likelihood or severity of adverse reactions related to sedation.
Antidepressants
In the placebo-controlled studies, a higher percentage of Zulresso-treated patients who used concomitant antidepressants reported sedation-related events.

USE IN SPECIFIC POPULATIONS
Pregnancy
Pregnancy Exposure
There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to antidepressants during pregnancy. Healthcare providers are encouraged to register patients by

calling the National Pregnancy Registry for Antidepressants at 1-844-405-6185.

Risk Summary

Based on findings from animal studies of other drugs that enhance GABAergic inhibition, Zulresso may cause fetal harm. There are no available data on Zulresso use in pregnant women to determine a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. In animal reproduction studies, malformations were not seen in rats or rabbits at plasma levels up to 5 and 6 times the maximum recommended human dose (MRHD), respectively. Developmental toxicities were seen in the fetuses of rats and rabbits at 5 and ≥3 times the plasma levels at the MRHD, respectively. Reproductive toxicities were seen in rabbits at ≥3 times the plasma levels at the MRHD. These effects were not seen in rats and rabbits at 2 and 1.2 times the plasma levels at the MRHD. Brexanolone administered to pregnant rats during pregnancy and lactation resulted in lower pup survival at doses which were associated with ≥2 times the plasma levels at the MRHD and a neurobehavioral deficit in female offspring at 5 times the plasma levels at the MRHD. These effects were not seen at 0.8 times and 2 times the plasma levels at the MRHD, respectively. In published animal studies, administration of other drugs that enhance GABAergic inhibition to neonatal rats caused widespread apoptotic neurodegeneration in the developing brain. The window of vulnerability to these changes in rats (postnatal days 0-14) corresponds to the period of brain development that takes place during the third trimester of pregnancy in humans. The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Lactation

Risk Summary

Available data from a lactation study in 12 women indicate that brexanolone is transferred to breast milk in nursing mothers. However, the relative infant dose (RID) is low, 1% to 2% of the maternal weight-adjusted dosage. Also, as Zulresso has low oral bioavailability in adults, infant exposure is expected to be low. There were no reports of effects of Zulresso on milk production. There are no data on the effects of Zulresso on a breastfed infant. Available data on the use of Zulresso during lactation do not suggest a significant risk of adverse reactions to breastfed infants from exposure to Zulresso. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Zulresso and any potential adverse effects on the breastfed child from Zulresso or from the underlying maternal condition.

Hepatic Impairment

Dosage adjustment in patients with hepatic impairment is not necessary. Modest increases in exposure to unbound brexanolone and modest decreases in exposure to total brexanolone were observed in patients with moderate to severe hepatic impairment (Child-Pugh ≥7) with no associated change in tolerability.

Renal Impairment

No dosage adjustment is recommended in patients with mild (eGFR 60 to 89 mL/minute/1.73 m^2), moderate (eGFR 30 to 59 mL/minute/1.73 m^2) or severe (eGFR 15 to 29 mL/minute/1.73 m^2) renal impairment. Avoid use of Zulresso in patients with end stage renal disease (ESRD) with eGFR of < 15 mL/minute/1.73 m^2 because of the potential accumulation of the solubilizing agent, betadex sulfobutyl ether sodium.

DRUG ABUSE AND DEPENDENCE

Controlled Substance

Zulresso contains brexanolone. (Controlled substance schedule to be determined after review by the Drug Enforcement Administration.)

Abuse

In a human abuse potential study, 90 mcg/kg, 180 mcg/kg (two times the maximum recommended infusion rate), and 270 mcg/kg (three times the maximum recommended infusion rate) Zulresso infusions over a one hour period were compared to oral alprazolam administration (1.5 mg and 3 mg). On positive subjective measures of "drug liking", "overall drug liking", "high" and "good drug effects", the 90 mcg/kg dosage produced scores that were similar to placebo. Scores on these positive subjective measures for both dosages of Zulresso 90 mcg/kg and 180 mcg/kg were lower than both alprazolam doses. However, the scores on the positive subjective measures for Zulresso 270 mcg/kg dosage were similar to those produced by both doses of alprazolam. In this study, 3% of subjects administered Zulresso 90 mcg/kg and 13% administered Zulresso 270 mcg/kg reported euphoric mood, compared to none administered placebo during the one-hour administration.

Dependence

In the PPD clinical studies conducted with Zulresso, end of treatment occurred through tapering. Thus, in these studies it was not possible to assess whether abrupt discontinuation of Zulresso produced withdrawal symptoms indicative of physical dependence. It is recommended that Zulresso be tapered according to the dosage recommendations, unless symptoms warrant immediate discontinuation.

CLINICAL STUDIES

The efficacy of Zulresso in the treatment of postpartum depression (PPD) was demonstrated in two multicenter, randomized, double-

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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.

Gastroenterology. 2019 Mar 2. pii: S0016-5085(19)32506-5. doi: 10.1053/j.gastro.2019.02.038. [Epub ahead of print]

HCV-induced epigenetic changes associated with liver cancer risk persist after sustained virologic response.

Hamdane N, Jühling F, Crouchet E, et al.

BACKGROUND AND AIMS: Chronic hepatitis C virus (HCV) infection is an important risk factor for hepatocellular carcinoma (HCC). Despite effective antiviral therapies, the risk for HCC is reduced but not eliminated following a sustained virologic response (SVR) to direct-acting antiviral (DAA) agents, and risk is higher in patients with advanced fibrosis. We investigated HCV-induced epigenetic alterations that might affect risk for HCC after DAA treatment in patients and mice with humanized livers. METHODS: We performed genome-wide ChIPmentation-based ChIP-Seq and RNA-seq analyses of liver tissues from 6 patients without HCV infection (controls), 18 patients with chronic HCV infection, 8 patients with chronic HCV infection cured by DAA treatment, 13 patients with chronic HCV infection cured by interferon therapy, 4 patients with chronic HBV infection, and 7 patients with nonalcoholic steatohepatitis, in Europe and Japan. HCV-induced epigenetic modifications were mapped by comparative analyses with modifications associated with other liver disease etiologies. uPA/SCID mice were engrafted with human hepatocytes, to create mice with humanized livers and given injections of HCV-infected serum samples from patients; mice were given DAAs to eradicate the virus. Pathways associated with HCC risk were identified by integrative pathway analyses and validated in analyses of paired HCC tissues from 8 patients with an SVR to DAA treatment of HCV infection. RESULTS: We found chronic HCV infection to induce specific genome-wide changes in H3K27ac, which correlated with changes in expression of mRNAs and proteins. These changes persisted following a sustained virologic response to DAAs or interferon-based therapies. Integrative pathway analyses of liver tissues from patients and mice with humanized livers demonstrated that HCV-induced epigenetic alterations were associated with liver cancer risk. Computational analyses associated increased expression of SPHK1 with HCC risk. We validated these findings in an independent cohort of patients with HCV-related cirrhosis (n=216), a subset of which (n=21) achieved viral clearance. CONCLUSIONS:In an analysis of liver tissues from patients with and without a sustained virologic response to DAA therapy, we identified epigenetic and gene expression alterations associated with risk for HCC. These alterations might be targeted to prevent liver cancer in patients treated for HCV infection.

AIDS. 2019 Mar 11. doi: 10.1097/QAD.0000000000002192. [Epub ahead of print]

Effects of comorbidity burden and age on brain integrity in HIV.

Saloner R, Heaton RK, Campbell LM, et al.

OBJECTIVE: The influence of confounding neurocognitive comorbidities in persons living with HIV (PLWH) on neuroimaging has not been systematically evaluated. We determined associations between comorbidity burden and brain integrity and examined the moderating effect of age on these relationships.

DESIGN: Observational, cross-sectional substudy of the CNS HIV Antiretroviral Therapy Effects Research (CHARTER) cohort.

METHODS: 288 PLWH (mean age=44.2) underwent structural MRI and MR spectroscopy as well as neurocognitive and neuromedical assessments. Consistent with Frascati criteria for HIV-associated neurocognitive disorders (HAND), neuromedical and neuropsychiatric comorbidity burden was classified as incidental (mild), contributing (moderate), or confounding (severe-exclusionary) to a diagnosis of HAND. Multiple regression modeling predicted neuroimaging outcomes as a function of comorbidity classification, age, and their interaction.

RESULTS: Comorbidity classifications were 176 incidental, 77 contributing, and 35 confounded; groups did not differ in HIV disease characteristics. Relative to incidental and contributing participants, confounded participants had less cortical gray matter

and more abnormal white matter and ventricular CSF, alongside more neuroinflammation (choline, myo-inositol) and less neuronal integrity (N-acetylaspartate). Older age exacerbated the impact of comorbidity burden: to a greater extent in the confounded group, older age was associated with more abnormal white matter (p=.017), less total white matter (p=.015), and less subcortical gray matter (p=.014).

CONCLUSIONS: Neuroimaging in PLWH reveals signatures associated with confounding neurocognitive conditions, emphasizing the importance of evaluating these among individuals with suspected HAND. Older age amplifies subcortical and white matter tissue injury, especially in PLWH with severe comorbidity burden, warranting increased attention to this population as it ages.

AIDS. 2019 Mar 11. doi: 10.1097/QAD.0000000000002190. [Epub ahead of print]

A generalizable method for estimating duration of HIV infections using clinical testing history and HIV test results.

Pilcher CD, Porco TC, Facente SN, et al.

OBJECTIVE:To determine the precision of new and established methods for estimating duration of HIV infection.

DESIGN: A retrospective analysis of HIV testing results from serial samples in commercially-available panels, taking advantage of extensive testing previously conducted on 53 seroconverters.

METHODS: We initially investigated four methods for estimating infection timing: 1) "Fiebig stages" based on test results from a single specimen; 2) an updated "4 gen" method similar to Fiebig stages but using antigen/antibody tests in place of the p24 antigen test; 3) modeling of "viral ramp-up" dynamics using quantitative HIV-1 viral load data from antibody-negative specimens; and 4) using detailed clinical testing history to define a plausible interval and best estimate of infection time. We then investigated a "two-step method" using data from both methods 3 and 4, allowing for test results to have come from specimens collected on different days.

RESULTS: Fiebig and "4 gen" staging method estimates of time since detectable viremia had similar and modest correlation with observed data. Correlation of estimates from both new methods (3 and 4), and from a combination of these two ("2-step method") was markedly improved and variability significantly reduced when compared with Fiebig estimates on the same specimens.

CONCLUSIONS: The new "two-step" method more accurately estimates timing of infection and is intended to be generalizable to more situations in clinical medicine, research, and surveillance than previous methods. An online tool is now available that enables researchers/clinicians to input data related to method 4, and generate estimated dates of detectable infection.

Am J Cardiol. 2019 Feb 23. pii: S0002-9149(19)30230-9. doi: 10.1016/j.amjcard.2019.02.025. [Epub ahead of print]

Physical activity, quality of life, and biomarkers in atrial fibrillation and heart failure with preserved ejection fraction (from the NEAT-HFpEF Trial)

Patel RB, Vaduganathan M, Felker GM, et al.

Although atrial fibrillation/atrial flutter (AF/AFL) and heart failure with preserved ejection fraction (HFpEF) frequently coexist, the influence of AF/AFL on physical activity, N-terminal pro-B-type natriuretic peptide (NT-proBNP), and quality of life in HFpEF is unclear and could have relevance to HFpEF trial design. We evaluated the association between AF/AFL and volitional physical activity, functional performance, NT-proBNP, and quality of life in patients with HFpEF in the Nitrate's Effect on Activity Tolerance (NEAT)-HFpEF trial. Of 99 patients with accelerometer data, 35 (35%) had AF/AFL. There were no differences between AF/AFL versus no AF/AFL in baseline average daily accelerometer units (ADAUs; 9.06 ± 0.54 vs 9.06 ± 0.48, p = 0.75), hours active per day (9.7 ± 2.3 vs 9.2 ± 2.2, p = 0.86), or 6-minute walk distance (6MWD; 307 ± 136m vs 321 ± 110m, p = 0.85). AF/AFL status was associated with higher baseline NT-proBNP (586 [25th to 75th percentile: 291 to 1254] pg/ml vs 154 [25th to 75th percentile: 92 to 288] pg/ml, p <0.001) and Kansas City Cardiomyopathy Questionnaire scores (69 [25th to 75th percentile: 46 to 88] vs 48 [25th to 75th percentile: 37 to 70], p = 0.01). Although treatment responses to isosorbide mononitrate measured by change in ADAUs, hours active per day, or 6MWD did not vary by AF/AFL status (interaction p >0.05 for all), AF/AFL patients had greater reductions in NT-proBNP after isosorbide mononitrate than patients without AF/AFL (interaction p <0.001), possibly due to regression to the mean. In conclusion, baseline measures and treatment-related changes in volitional physical activity (ADAUs) and functional performance (6MWD) did not differ by AF/AFL in NEAT-HFpEF, whereas NT-proBNP did. In HFpEF-where AF/AFL prevalence is high-functional measures may be superior to natriuretic peptides as trial endpoints.

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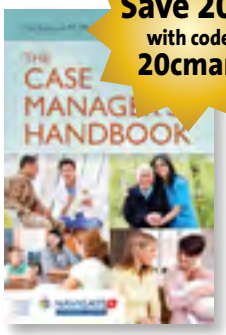

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J Card Fail. 2019 Mar 12. pii: S1071-9164(18)30917-5. doi: 10.1016/j.cardfail.2019.03.007. [Epub ahead of print]

Nutrition, obesity and cachexia in patients with heart failure: a consensus statement from the HFSA Scientific Statements Committee.

Vest AR, Chan M, Deswal A, et al.

Dietary guidance for patients with heart failure (HF) has traditionally focused on sodium and fluid intake restriction, but dietary quality is frequently poor in patients with HF and may contribute to morbidity and mortality. Restrictive dietary counselling can lead to inadequate intake of macronutrients and micronutrients by patients with HF, with the potential for deficiencies of calcium, magnesium, zinc, iron, thiamine, vitamins D, E, K, and folate. Although inadequate intake and low plasma levels of micronutrients have been associated with adverse clinical outcomes, evidence supporting therapeutic repletion is limited. Intravenous iron, thiamine and coenzyme Q10 have the most clinical trial data for supplementation. There is also limited evidence supporting protein intake goals. Obesity is a risk factor for incident HF and weight loss is an established approach for preventing HF, with a role for bariatric surgery in patients with severe obesity. However weight loss for patients with existing HF and obesity is a more controversial topic due to an obesity survival paradox. Dietary interventions and pharmacologic weight loss therapies are under-studied in HF populations. There are also limited data for optimal strategies to identify and address cachexia and sarcopenia in patients with HF, with at least 10-20% of patients with ambulatory systolic HF developing clinically significant wasting. Gaps in our knowledge about nutrition status in patients with HF are outlined in this Statement and strategies to address the most clinically-relevant questions proposed.

Ann Surg Oncol. 2018 Dec;25(13):3936-3942. doi: 10.1245/s10434-018-6764-3. Epub 2018 Oct 1.

Are staging computed tomography (CT) scans of the chest necessary in pancreatic adenocarcinoma?

Mehtsun WT, Chipidza FE, Fernández-Del Castillo C, et al.

BACKGROUND: There is no consensus on the use of chest imaging in pancreatic ductal adenocarcinoma (PDAC) patients. Among PDAC patients, we examined the use of chest computed tomography (CT) over time and determined whether the use of chest CT led to a survival difference or change in management via identification of indeterminate lung nodules (ILNs).

METHODS: Retrospective clinical data was collected for patients diagnosed with PDAC from 1998 to 2014. We examined the proportion of patients undergoing staging chest CT scan and those who had ILN, defined as ≥ 1 well-defined, noncalcified lung nodule(s) ≤ 1 cm in diameter. We determined time to overall survival (OS) using multivariate Cox regression. We also assessed changes in management of PDAC patients who later developed lung metastasis only.

RESULTS: Of the 2710 patients diagnosed with PDAC, 632 (23%) had greater than one chest CT. Of those patients, 451 (71%) patients had ILNs, whereas 181 (29%) had no ILNs. There was no difference in median overall survival in patients without ILNs (16.4 [13.6, 19.0] months) versus those with ILN (14.8 [13.6, 15.8] months, P = 0.18). Examining patients who developed isolated lung metastases (3.3%), we found that staging chest CTs did not lead to changes in management of the primary abdominal tumor.

CONCLUSIONS: Survival did not differ for PDAC patients with ILNs identified on staging chest CTs compared with those without ILNs. Furthermore, ILN identification did not lead to changes in management of the primary abdominal tumor, questioning the utility of staging chest CTs for PDAC patients.

ASAIO J. 2018 May/Jun;64(3):295-300. doi: 10.1097/MAT.0000000000000685.

Inferior transplant outcomes of adolescents and young adults bridged with a ventricular assist device.

Rizwan R, Bryant R 3rd, Zafar F, et al.

Adolescents, who are thought to have compliance issues, are well known to have poor heart transplant (HTx) outcomes. This "effect" has recently been demonstrated to extend to age 29. The study sought to investigate whether the poor outcomes for HTx related to adolescent age are also observed in recipients who are bridged to transplant (BTT) with a ventricular assist device (VAD) and whether this effect extends beyond the standard definition of adolescent age 12-18 years. All HTx BTT with a VAD in recipients 8-39 years were identified in the United States Organ Sharing (UNOS) database (1 January 2005 to 30 June 2016). Based on the Kaplan-Meier survival comparison for age year, patients were divided into three groups: Group 1 (8-14 years), group 2 (15-29 years), and group 3 (30-39 years). A total of 1,848 HTx were

bridged with a VAD. A decline in post-HTx 5 years survival was noted after 14 years of age, which improved at around 30 years of age. Group 1 had 237 (13%) HTx, group 2 had 787 (43%) HTx, and group 3 had 823 (44%) HTx. Group 2 (15-29 years) had worse post-HTx survival compared with group 1 ($p < 0.001$) and group 3 ($p = 0.005$). On subdividing group 2 (15-29 years) into "older adolescents" (15-17 years) and "young adults" (18-29 years), post-HTx survival was similar between the two subgroups ($p = 0.353$). In conclusion, older adolescents and young adults, both, have similarly poor post-HTx survival when BTT with a VAD compared with other age groups. These groups are generally categorized into different broad pediatric and adult age groups; however, these similarities should be carefully considered when formulating treatment protocols for older adolescents and young adults.

JAMA. 2019 Feb 12;321(6):553-561. doi: 10.1001/jama.2018.21442.

Effect of intensive vs standard blood pressure control on probable dementia: a randomized clinical trial.

SPRINT MIND Investigators for the SPRINT Research Group, Williamson JD, Pajewski NM, Auchus AP, et al.

IMPORTANCE: There are currently no proven treatments to reduce the risk of mild cognitive impairment and dementia.

OBJECTIVE: To evaluate the effect of intensive blood pressure control on risk of dementia.

DESIGN, SETTING, AND PARTICIPANTS: Randomized clinical trial conducted at 102 sites in the United States and Puerto Rico among adults aged 50 years or older with hypertension but without diabetes or history of stroke. Randomization began on November 8, 2010. The trial was stopped early for benefit on its primary outcome (a composite of cardiovascular events) and all-cause mortality on August 20, 2015. The final date for follow-up of cognitive outcomes was July 22, 2018.

INTERVENTIONS: Participants were randomized to a systolic blood pressure goal of either less than 120 mm Hg (intensive treatment group; n = 4678) or less than 140 mm Hg (standard treatment group; n = 4683).

MAIN OUTCOMES AND MEASURES: The primary cognitive outcome was occurrence of adjudicated probable dementia. Secondary cognitive outcomes included adjudicated mild cognitive impairment and a composite outcome of mild cognitive impairment or probable dementia.

RESULTS: Among 9361 randomized participants (mean age, 67.9 years; 3332 women [35.6%]), 8563 (91.5%) completed at least 1 follow-up cognitive assessment. The median intervention period was 3.34 years. During a total median follow-up of 5.11 years, adjudicated probable dementia occurred in 149 participants in the intensive treatment group vs 176 in the standard treatment group (7.2 vs 8.6 cases per 1000 person-years; hazard ratio [HR], 0.83; 95% CI, 0.67-1.04). Intensive BP control significantly reduced the risk of mild cognitive impairment (14.6 vs 18.3 cases per 1000 person-years; HR, 0.81; 95% CI, 0.69-0.95) and the combined rate of mild cognitive impairment or probable dementia (20.2 vs 24.1 cases per 1000 person-years; HR, 0.85; 95% CI, 0.74-0.97).

CONCLUSIONS AND RELEVANCE: Among ambulatory adults with hypertension, treating to a systolic blood pressure goal of less than 120 mm Hg compared with a goal of less than 140 mm Hg did not result in a significant reduction in the risk of probable dementia. Because of early study termination and fewer than expected cases of dementia, the study may have been underpowered for this end point.

PLoS One. 2018 Sep 26;13(9):e0204516. doi: 10.1371/journal.pone.0204516. eCollection 2018.

Common psychiatric and metabolic comorbidity of adult attention-deficit/hyperactivity disorder: a population-based cross-sectional study..

Chen Q, Hartman CA, Haavik J, et al.

Attention-deficit/hyperactivity disorder (ADHD) is often comorbid with other psychiatric conditions in adults. Yet, less is known about its relationship with common metabolic disorders and how sex and ageing affect the overall comorbidity patterns of adult ADHD. We aimed to examine associations of adult ADHD with several common psychiatric and metabolic conditions. Through the linkage of multiple Swedish national registers, 5,551,807 adults aged 18 to 64 years and living in Sweden on December 31, 2013 were identified and assessed for clinical diagnoses of adult ADHD, substance use disorder (SUD), depression, bipolar disorder, anxiety, type 2 diabetes mellitus (T2DM), and hypertension. Logistic regression models and regression standardization method were employed to obtain estimates of prevalence, prevalence difference (PD), and prevalence ratio (PR). All comorbid conditions of interest were more prevalent in adults with ADHD (3.90% to 44.65%) than in those without (0.72% to 4.89%), with the estimated PRs being over nine for psychiatric conditions ($p < 0.001$) and around

two for metabolic conditions ($p < 0.001$). Sex differences in the prevalence of comorbidities were observed among adults with ADHD. Effect modification by sex was detected on the additive scale and/or multiplicative scale for the associations of adult ADHD with all comorbidities. ADHD remained associated with all comorbidities in older adults aged 50 to 64 when all conditions were assessed from age 50 onwards. The comorbidity patterns of adult ADHD underscore the severity and clinical complexity of the disorder. Clinicians should remain vigilant for a wide range of psychiatric and metabolic problems in ADHD affected adults of all ages and both sexes.

Semin Dial. 2019 Mar 8. doi: 10.1111/sdi.12778. [Epub ahead of print]

Achieving dialysis safety: the critical role of higher-functioning teams.

Wong LP.

The potential for harm from errors and adverse events in dialysis is significant. Achieving a culture of safety in dialysis to reduce the potential harm to patients has been challenging. Recently, improving dialysis safety has been highlighted by Nephrologists Transforming Dialysis Safety (NTDS), a national initiative to eliminate dialysis infections. Other aspects of dialysis safety are important, though less measurable. Approaching dialysis safety from a systematic thinking view helps us to understand the need for leadership and high-functioning teams to deliver safe, reliable care in dialysis facilities. Resilience in healthcare is embodied by strong teamwork-interdependent professionals working together with clarity of goals and communication. This paper reframes the role of dialysis facility medical directors as leaders of these high-functioning teams. Alignment between nephrologists and dialysis management is necessary for these teams to function. This will require nephrologists to embrace their leadership roles as medical directors and for dialysis facility management to provide adequate operational support. The accountability for dialysis safety is shared between the nephrologists and dialysis organizations; coleadership is required for safety culture and high-functioning dialysis teams to develop.

Int J Geriatr Psychiatry. 2018 May;33(5):779-785. doi: 10.1002/gps.4860. Epub 2018 Mar 2.

Telephone-based management of chronic pain in older adults in an integrated care program.

Helstrom A, Haratz J, Chen S, et al.

OBJECTIVE: Few studies have explored behavioral strategies for managing chronic pain in older adults. Pain Care Management (PCM) is a telephone-based behavioral intervention for chronic pain. The present study examined chronic pain characteristics among older adults and tested the delivery of PCM as an adjunct to depression and anxiety care management. METHODS: Participants were drawn from a state-sponsored program offering care management services to community members aged 65 and older who were prescribed a psychotropic medication by a primary care provider. Chronic pain information was collected for all participants in the state program (N = 250) and treatment outcome data were collected for a subset with significant chronic pain. Eighty participants with high chronic pain interference were offered PCM and compared to 80 participants with chronic pain who received monitoring only on depression, anxiety, and pain interference outcomes. RESULTS: Chronic pain was identified in 14% of older adults newly prescribed a psychotropic medication. Compared to monitoring only, PCM participants had higher odds of seeing a reduction of 2 or more points in pain interference at 6 months. Pain care management participants' anxiety scores significantly decreased over the study period. CONCLUSIONS: Older adults treated with psychotropic medications often also experience chronic pain that interferes with daily activities. A telephone-based care management intervention is acceptable and feasible with an older community-based population and can lead to improvements in anxiety symptoms and interference from chronic pain. Further research will help to refine interventions that may help improve symptoms and increase functioning with this population.

CMSA Announces Newly Elected Members of Board of Directors 2019–2023

CMSA's membership has elected a president-elect, secretary, and two national directors to the CMSA National Board. These leaders begin their terms at the end of CMSA's 29th Annual Conference & Expo held this year in Las Vegas, Nevada, the week of June 10–14, 2019.

"We are thrilled to see our new leadership reflect the uniqueness and diversity of the CMSA membership," stated Kathleen Fraser, MSN, MHA, RN-BC, CCM, CRRN, CMSA, national executive director. "We represent case managers across the full continuum of care, and the experience, knowledge, and enthusiasm of our newly elected board members will advance the mission of CMSA and benefit each member of our community. As Helen Keller said, "Alone we can do so little, together we can do so much."

CMSA president Jose Alejandro, PhD, RN, FAAN, remarked, "One of the significant strengths of CMSA is our engaged and diversified membership and their willingness to be servant leaders. CMSA and our membership has a history of substantially and positively impacting healthcare delivery within the United States and internationally. I look forward to working with our new board members in the coming year to further our impact through collaboration, systems thinking, innovation, and evidence-based practice.

Additional new members are:

- PRESIDENT ELECT: Melanie Ann Prince, Colonel, BSN, MSN, RN-BC, CCM; 2019-2023
- SECRETARY: Janet Coulter, RN, MSN, MS, CCM; 2019-2021
- DIRECTORS: Tracey Armstrong, BSN, RN, MBA, PHN, CCM; 2019-2022
- Colleen Morley, DNP, RN, CMCN, ACM-RN; 2019-2022 ■

Scholarship Applications Now Being Accepted

The Patrice V. Sminkey Memorial Foundation was organized to offer charitable, educational, and/or scientific purposes to improve and enhance patient care. The foundation provides and supports educational programs and initiatives to broaden and advance the education and training of professional case managers. The Spring scholarship application window is open through April 30, 2019.

To recognize a professional case manager who is an outstanding role model and mentor, an award up to a maximum of $1,000 will be given in support of participation at a continuing education event (tuition, travel, and expenses), research in the field of case management, CCM certification, attendance at the CCMC New World Symposium, and other educational opportunities. Learn more and complete your application today. ■

Tumor Mutational Burden as a Biomarker

Evidence is increasing that the biomarker tumor mutational burden (TMB) could be helpful in determining which patients will benefit from immunotherapy agents, especially as first-line therapy.

Results reported in the *Journal of Clinical Oncology* showed that TMB was a useful predictor of how patients with advanced or metastatic non–small-cell lung cancer responded to a combination of nivolumab (Opdivo®) and low-dose ipilimumab (Yervoy®) as a first-line treatment. TMB was a useful predictor of the objective response rate and the progression-free survival in patients both above and below a commonly used threshold for assessing PD-L1 expression.

However, TMB is not a straightforward determinant for reshaping cancer treatment. A higher TMB might not always be a bad marker if the mutations produce proteins that are better targets for treatment drugs. ■

Giving and Getting Referrals Webinar

All types of providers need to know how to get more referrals from hospitals without breaking the law. And hospital discharge planners/case managers need to know the rules so that the referral process remains in compliance!

Join us for this teleconference (May 8, 1:00-2:30 pm EST) to address crucial questions for both providers and discharge planners, such as:

- Can home care providers participate in discharge planning meetings?
- Should home care providers have access to case managers and patients before discharge?
- What do regulations and interpretive guidelines for discharge planning say about giving and getting referrals?
- How can providers and case managers use Preferred Provider Agreements?

To register, contact Elizabeth Hogue at elizabethhogue@elizabethhogue.net.

An all-day in-demand recording of the webinar will be available May 15. ■

Marketplace Plans Denied an Average of Nearly 1 in 5

Healthcare.gov marketplace insurers denied nearly 1 out of every 5 claims (19%) submitted for in-network services in 2017, and enrollees only appealed a tiny share (0.5%) of those denied claims, according to a Kaiser Family Foundation analysis of recently released claims data.

The analysis finds a huge variation across insurers, with average denial rates as low as 1% and as high as 45%. Denial rates also vary across states, though individual insurers in the same state also show wide variation. For instance, Florida's 6 insurers denied 11% of claims, though the denial rates among the 6 insurers reporting data in the state range from 2% to 32%.

The Affordable Care Act requires insurers to report data about claims denials and appeals and other metrics to encourage transparency about how insurance coverage works in practice for enrollees. The analysis relies on data files released by the Centers for Medicare & Medicaid Services and compiled by Kaiser Family Foundation. It examines nearly 230 million claims submitted to 130 insurers selling individual market major medical health plans through healthcare.gov in 2017.

Reasons for denial can include both administrative issues such as improperly submitted or duplicative claims and coverage issues such as denials for services that the insurer determines are not medically necessary.■

PharmaFacts for Case Managers

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blind, placebo-controlled studies (referred to as Studies 1 and 2) in women (18 to 45 years) with PPD who met the Diagnostic and Statistical Manual of Mental Disorders criteria for a major depressive episode (DSM-IV) with onset of symptoms in the third trimester or within 4 weeks of delivery. In these studies, patients received a 60-hour continuous intravenous infusion of Zulresso or placebo and were then followed for 4 weeks. Study 1 (NCT02942004) included patients with severe PPD (Hamilton Depression Rating Scale (HAM-D) score ≥ 26), and Study 2 (NCT02942017) included patients with moderate PPD (HAM-D score of 20 to 25). A titration to the recommended target dosage of 90 mcg/kg/hour was evaluated in both studies (patients received 30 mcg/kg/hour for 4 hours, 60 mcg/kg/hour for 20 hours, 90 mcg/kg/hour for 28 hours, followed by a taper to 60 mcg/kg/hour for 4 hours and then 30 mcg/kg/hour for 4 hours). A titration to a target dosage of 60 mcg/kg/hour (patients received 30 mcg/kg/hour for 4 hours, 60 mcg/kg/hour for 52 hours, then 30 mcg/kg/hour for 4 hours) was also evaluated in Study 1.

Demographic and baseline disease characteristics were generally similar across treatment groups in the pooled Studies 1 and 2. Most patients were White (63%) or Black (34%); 18% of patients identified as Hispanic or Latina; the average age of women receiving Zulresso was 28 years. Most patients (76%) had onset of PPD symptoms within 4 weeks after delivery, with the remainder having onset during the third trimester. Baseline oral antidepressant use was reported for 23% of patients.

The primary endpoint was the mean change from baseline in depressive symptoms as measured by the HAM-D total score at the end of the infusion (Hour 60). A pre-specified secondary efficacy endpoint was the mean change from baseline in HAM-D total score at Day 30. In both placebo-controlled studies, titration to a target dose of Zulresso 90 mcg/kg/hour was superior to placebo in improvement of depressive symptoms. In a group of 38 patients in Study 1, a Zulresso titration to a target dose of 60 mcg/kg/hour was also superior to placebo in improvement of depressive symptoms.

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Zulresso injection is supplied as 100 mg brexanolone in 20 mL (5 mg/mL) single-dose vials containing a sterile, preservative-free, clear, colorless solution.

Storage and Handling

Store the undiluted Zulresso product at 2°C to 8°C (36°F to 46°F). Do not freeze. Store protected from light.

The diluted product in the infusion bag can be used at room temperature for up to 12 hours. If the diluted product is not used immediately after dilution, store under refrigerated conditions for up to 96 hours.

Zulpresso is manufactured for Sage Therapeutics.

CE II Ethical Considerations for Care Coordination for Clients with Mental Illness *continued from page 31*

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Ready, Set, Transition: Navigating Value-Based Care Initiatives Through Effective Post-Acute Care Transitions *continued from page 13*

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The Opioid Epidemic: A Public Health Challenge *continued from page 3*

In 2013 we witnessed another increase in opioid overdoses involving illicitly manufactured fentanyl.

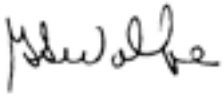
This epidemic affects individuals from all walks of life regardless of race, gender, or economic status. Even individuals who do not use or abuse opioids are affected if they have a friend, relative, or loved one with addiction issues. Many people are affected by the economic burden and emotional distress caused by opioid addiction.

The opioid epidemic won't be solved by one person or a single program. Every health care provider must want to make a difference. Case managers are in a unique position to make a difference because they have firsthand experience with the dangers of overprescribing opioids. The first thing case managers need to do is to become educated about opioids. Know the dangers, signs, and symptoms of opioid abuse. Engage in the hard conversations openly and reduce the stigma of addiction. Talk to your patients and the health care teams you work with about opioids. Be nonjudgmental. Work together! Promote the use of overdose-reversal drugs. Be knowledgeable about pain management.

Other initiatives and strategies that a case manager can participate in include:

- Building prevention efforts
- Improving data and tracking
- Supporting healthcare providers and health systems with evidence-based decision-making tools
- Partnering with public safety agencies
- Encouraging the consumer to make safe choices

Working together, we can make a difference in addressing perhaps the worst public health crisis of all time!



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ACCM: Improving Case Management Practice through Education

Facilitating Return to Work for Mental Health Diagnoses *continued from page 6*

music with headphones can help block out distractions and interruptions.

Other possible accommodations include:

- Temporary telecommuting to support resumption of the work routine
- Job coaching or mentoring to provide additional workplace support
- Written assignments and task lists when an individual has problems focusing
- Employee Assistance Program (EAP) services for additional support

It is important to remember that qualified individuals with mental health conditions may also be protected from workplace discrimination under the Family and Medical Leave Act (FMLA) and/or the Americans with Disabilities Act (ADA). Some states have additional requirements for documentation when a reasonable accommodation is required. For example, last fall new legislation in New York City required employers to provide employees with written documentation of the outcome of reasonable accommodation requests.

Throughout the process of designing and implementing the RTW plan, the CDMS is uniquely positioned to help support the individual and minimize the lost-time impact on the employer. Whether the diagnosis involves physical illness, mental illness, or both, an individualized RTW plan is the key to success. CM

A Certified Disability Management Specialist (CDMS) can be instrumental in facilitating a supportive and successful return-to-work plan.

Continuous Glucose Monitoring: Complete Care Management Solution for Diabetes *continued from page 14*

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Patients' Preferences for Caregivers
continued from page 9

not engage in such practices. In short: racism cannot be tolerated in the health care industry.

There is one exception to this general rule that occurs when patients ask for caregivers of the same sex because the patient has concerns about bodily privacy. Then it is acceptable to assign only same-sex caregivers to patients who have made such requests.

In addition to concerns about discrimination, providers must also be concerned about risk management when they honor such requests. Especially in view of increasing shortages of staff, limitations on available caregivers may mean that patients' needs cannot be met by staff members who are acceptable to patients. In view of staffing shortages, the fewer caregivers who are permitted to care for certain patients, the more likely it is that patients' needs will go unmet. Unmet patient needs are, in turn, likely to significantly enhance the risk associated with providing care to such patients.

Pressure to honor patients' requests may be at its greatest when patients receive services at home. Patients who will accept any caregiver assigned to them in institutional settings somehow feel that they have the right to decide who may provide services in their homes. On the contrary, with the exception noted above, assignments of staff for services rendered at home should be made without regard to client preference, just as assignments are made in institutional settings.

How should managers respond when patients tell them not to assign certain staff members to them? First, they should explain that the organization does not discriminate and that to avoid assignments based on racial, cultural, or religious background may constitute unlawful discrimination. Then staff should explain that if limitations on caregivers were acceptable, the provider may be unable to render services to the patient at all because they may not have enough staff. The bottom line is that staff will be assigned without regard to patient preference in order to prevent discrimination and to help ensure quality of care.

Needless to say, patients' requests and managers' responses must be specifically documented in patients' charts. Documentation that says patients expressed preferences for certain caregivers or rejected certain types of caregivers is too general. Specific requests and responses of staff must be documented.

After patients have expressed what may amount to prejudice against certain groups of caregivers, managers must follow up and monitor for inappropriate behavior by patients directed at caregivers who are not preferred. Managers should be alert to the potential for this problem and should follow up with patients and caregivers to help ensure that caregivers are receiving the respect they deserve. Follow-up activities and ongoing monitoring should also be specifically documented.

First and foremost, discrimination cannot be permitted in the health care industry. In addition, providers cannot afford to lose or alienate a single caregiver based on discrimination or inappropriate behavior by patients. Providers also certainly cannot afford to use precious resources to defend against lawsuits based on allegations of discrimination. As Alexander Hamilton said in The Federalist Papers, "The subject speaks its own importance." 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.*

Certification: The "Business Case" for Employers
continued from page 4

ground and encourages mutual professional respect. In addition to greater collegiality, there is a higher standard of expectations among all professionals and a shared commitment to excellence.

While certification remains a personal accomplishment—a capstone of advanced practice for case managers from across multiple disciplines—the benefit of this professional achievement goes beyond the individual. Employers of case managers are able to distinguish the services provided by their teams composed of individuals who hold themselves to a higher standard. CM

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