CareManagement

JOURNAL OF THE COMMISSION FOR CASE MANAGER CERTIFICATION | THE CASE MANAGEMENT SOCIETY OF AMERICA | THE ACADEMY OF CERTIFIED CASE MANAGERS

Vol. 26, No. 2 APRIL/MAY 2020

CELEBRATING

25 YEARS

CCMC New World SYMPOSIUM® 2020

REACHING NEW HEIGHTS

Symposium coverage starts on page 12

IMPROVING CASE MANAGEMENT PRACTICE THROUGH EDUCATION

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Vol. 26, No. 2, April/May 2020

INSIDE THIS ISSUE

CONTINUING EDUCATION ARTICLES:

SPECIAL SECTIONS:

DEPARTMENTS:

CareManagement

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Gary S. Wolfe

Celebrating 25 Years

It was the Fall of 1994, and I was serving as President of the Case Management Society of America (CMSA). I was invited by Howard Mason to explore the possibility of a professional journal for case managers. We met and, after a series of discussions, the publication that is now known as *CareManagement* was born. The first issue published in April 1995—25 years ago.

Originally, we were the official publication of CMSA, a vehicle to communicate with CMSA members, and a journal to advance the case management body of knowledge. It was the mid-1990s. The Commission for Case Manager Certification had recently formed and had been certifying case managers since 1993. CMSA was a young fledging organization. Most case managers worked for insurance companies. Medical case managers were trained on the job.

A lot has changed in 25 years. There has been a proliferation of case managers in all health care settings. Knowledge, science, systems, reimbursement, and public policy have all had an impact on case management. In keeping with the times, *CareManagement* has grown and transformed from a print publication to an electronic journal. We are now the official publication of the Academy of Certified Case Managers, the Commission for Case Manager Certification, and a publication of the Case Management Society of America.

The mission of *CareManagement* always has been to improve case management practice through education. We do this by publishing self-study courses in the journal. In our 25 years of publishing, we have offered over 700 hours of PACE (CCMC), CDMS, and RN-approved continuing education. As I said in my inaugural editorial 25 years ago, "We exist to serve you—as a vehicle to simulate thought, as a forum in which trends can be identified, and as a meeting place for case managers from all practice settings to share information and opinions." Those are the reasons we continue to publish the journal.

In 25 years, we have had three executive editors: Susan Tannen, Denise McClinton, and Jennifer Maybin. They have all served uniquely and with distinction. With this issue, I am sad to announce the retirement of our current executive editor, Jennifer Maybin. I would like to thank Jennifer for her dedication and years of service to the journal.

I also want to recognize the work of Laura Campbell, who serves as our art director and webmaster. She does an outstanding job in making sure the journal looks professional and is easy to read. Esther Tazartes is our copy editor extraordinaire. She reviews the articles to improve readability and ensures that the copy is free of grammatical errors. The real credit for *CareManagement* goes to Howard Mason, RPh, MS. With a background in pharmaceuticals and medical communications, Howard had the vision for case management. He took a risk! Just look what *CareManagement* is today: the leading professional journal for professional case managers. I salute and applaud all of the staff of *CareManagement*.

I would also like to thank our authors. *CareManagement* would not exist without the many authors who contribute their knowledge and wisdom so that all case managers can improve their practice. I invite anyone who is interested in contributing to the case management body of knowledge to contact me about writing a manuscript.

Most importantly I want to recognize all the readers of *CareManagement*.

continues on page 40

THE COMMISSION FOR CASE MANAGER CERTIFICATION

CERTIFICATION OF DISABILITY MANAGEMENT SPECIALISTS COMMISSION

Social Determinants of Health and Return to Work

Patty Nunez, MA, CRC, CDMS, CCM, and Stan Scioscia, M.Ed., CRC, CDMS

It is well recognized that the social determinants of health, broadly defined as the environment and conditions in which people live and work, affect the health of individuals and populations. These factors also account for most of the disparities in access to health care resources and outcomes.

As the Office of Disease Prevention and Health Promotion observed, "Our health is…determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be."

In this column, we address social determinants of health within a context that may be less familiar to professional case managers: how factors such as socioeconomic status, environment, education/literacy, health literacy, and language directly impact the success of a return-to-work plan with the goal of enabling an ill or injured worker to resume work and full functioning. Greater familiarity with social determinants of health can support the practice of professional case managers, including those who hold the Certified Case Manager® (CCM) credential, as well as disability management professionals who hold the Certified Disability Management Specialist (CDMS) certification.

Social determinants of health and their impact on desired outcomes have an influence in all 9 phases of the case management process: screening, assessing, stratifying risk, planning, implementing (care coordination), following up, transitioning (transitional care), communication posttransition, and evaluating. This approach applies in all settings, including primary and acute care, disability management, and workers' compensation.

Disability compensation systems cover an array of benefits, including short-term and long-term disability for nonoccupational illnesses and injuries; statutory disability offered by states (such as California's State Disability Insurance and New York State's Disability Benefits Law); and state-mandated workers' compensation coverage for work-related injuries and illnesses. Although our discussion here focuses on workers' compensation, insights apply more broadly to disability management and absence management in which the goal is to help employees access the care they need and return to gainful employment.

Social Determinants and Workers' Compensation

When an employee is injured on the job, the cost of care directly related to the injury is covered by workers' compensation, in accordance with statutes that vary from state to state. In addition, workers typically receive anywhere from 55% to 66 2/3% of their average weekly wages, according to state standards. While these benefits and wage replacement may seem to lessen the influence of social determinants of health, these socioeconomic and environment factors are still impactful. For example, workers who receive minimum wage may be unable to support themselves and their families on reduced wages. Thus, a workplace injury can result in a significant financial burden that undermines healing and rehabilitation.

An example is a laborer whose job requires heavy lifting. After incurring a back injury, the worker, who has minimal education (no high school diploma) and no advanced skills, resists taking time off work. The worker may choose not to report the injury in order to continue working full time and receive full wages.

Patty Nunez, MA, CRC, CDMS, CCM, *is a Commissioner of the Commission for Case Manager Certification, the first and largest nationally accredited case management certification organization, credentialing over 50,000 professional case managers and disability management specialists. Patty is a director within the Claim Supply Management office of CNA and is based in Orange County, California.*

Stan Scioscia, M.Ed., CRC, CDMS, *is also a CCMC Commissioner and has entered his 40th year in the disability management field. He is currently Disability Management Services Coordinator with the University of California, Davis, assisting campus employees and departments with workplace accommodations and return-to-work facilitation.*

Social determinants of health impact outcomes across the spectrum of health and human services. In return-to-work planning, social determinants of health play a role beyond the statutory components of workers' compensation. By understanding the socioeconomic status, education, literacy, and environmental factors of injured workers, case managers and disability management specialists can enhance their advocacy in pursuit of desired outcomes.

In addition, individuals may not have had positive experiences with the health care system in the past and may also be influenced by cultural perceptions such as needing to be "tough and bite the bullet" and assume responsibility for taking care of their families without complaint. As a result, these individuals may not comply with treatment protocols and may return to work sooner than is medically advisable and are thus at risk for reinjury, cumulative trauma, and/or a more serious and costly disabling condition.

Such cases can be further exacerbated by a lack of literacy and/or language skills that undermine the individual's ability to follow medical instructions. The injured worker may also hold certain perceptions; for example, the belief that "physical therapy hurts more than it helps." These misperceptions and misunderstandings can become serious impediments to recovery and return to work. In addition, the worker may have a second job to supplement income. When individuals become injured on one job but continue to work at another job (despite having an impairment), there could be an impact on their health, on healing to reach full recovery, and on compliance under workers' compensation.

This cursory summary highlights the complexity of such cases and the need for CCMs and CDMSs to identify and address the social determinants of health as part of the intake. For example:

- Given the individual's wage history (which is part of the information provided in workers' compensation cases), what is the impact of reduced wages on the individual? Are they the sole earner within the family? Are they also supporting an extended family?
- What is the person's family life/support system? Are they the caregiver? Are there people in their support system who understand the health regimen and medical instructions?
- Does the presence of other health conditions (comorbidities) such as obesity impact the person's ability to heal? Are there negative lifestyle choices (eg, tobacco use or overuse of alcohol and recreational drugs)? Does the employer offer an Employment Assistance Program (EAP) to support wellness, better nutrition, or access to behavioral health resources?
- What does work mean to this individual in the context of their personal values?
- What is the individual's previous experience with the health care system? Does the person know anyone who has benefited from physical therapy?
- Are workplace accommodations applicable? Can the employee's job duties be modified or can the person be temporarily reassigned to a transitional position as they recuperate and heal?

Such questions can establish an open dialogue with the injured worker to support health and healing. For example, the case manager or disability manager can share examples of other workers with similar injuries who benefited from physical therapy or they may accompany the worker to the first physical therapy appointment to facilitate a discussion of what is involved and how it will help. By building rapport and addressing the individual's concerns and perceptions, the case manager/disability manager is able to tie the treatment and therapy directly with the person's goals, whether those goals are to feel stronger or to lead a healthier lifestyle, with the ultimate goal of returning to work.

Throughout the process, the case manager/disability manager can try to view health care through the "eyes and ears" of an injured worker—as unfamiliar terrain. This requires empathy and the suspension of judgment, particularly if the individual does not appear to be following the doctor's instructions. The reason may not be a disregard for the medical recommendations; rather, it may be a lack of understanding or a conflict with the person's underlying beliefs about their own health and independence.

In summary, social determinants of health impact outcomes across the spectrum of health and human services. In return-to-work planning, social determinants of health play a role beyond the statutory components of workers' compensation. By understanding the socioeconomic status, education, literacy, and environmental factors of injured workers, case managers and disability management specialists can enhance their advocacy in pursuit of desired outcomes. CM

Renewal and New Beginnings

Jose Alejandro, PhD, RN-BC, CCNM, FACHE, FAAN

2020 is the Year of the Metal Rat, the first of the 12 Chinese zodiac signs. It signifies renewal and new beginnings! As a professional case manager, it is the perfect time for lifelong learning, development, advocacy, and resiliency. Here are my thoughts about the opportunities ahead of us:

Lifelong learning. Today, the traditional classroom setting has been flipped and replaced with other nontraditional learning environments like digital media, informal learning, and incidental learning.[1] More than ever, we learn through experience and by doing. Evidence-based practice allows us to transfer and replicate best-in-class learning and knowledge from others, and, more importantly, remember the importance of learning from mistakes.

Professional development continues our journey from novice to expert.[2] We all have room to grow and to build generational knowledge within the case management field. The Case Management Society of America (CMSA) offers a number of opportunities to grow professionally: webinars, white papers, conferences, local chapter meetings, and writing. From my personal perspective, I process and acquire a great deal of knowledge as I develop articles for *CMSA Today,*™ *Professional Case Management,* and other professional journals. Professional and scholarly writing also further develops our critical thinking skills and reflective practice.

As professional case managers, we need to be cognizant of our obligation to build a legacy that assists the next generation of individuals to effectively execute our important role. CMSA is committed to developing a vision that deploys strategies to strengthen our profession into the future.

Advocacy. As professional case managers we all know the important role that we have as advocates. Michelle Baker's 2019 and 2020 articles on field case management advocacy are perfect examples of the critical role we have in navigating our health care delivery system, networking with community stakeholders, and advocating for the specific concerns of the individuals we serve. Ms. Baker poignantly describes how communication and collaboration is "intensified" as we manage and facilitate individual care transitions.[3,4]

Resiliency. Taking care of ourselves is imperative but often neglected. Self-care requires us to develop behaviors and habits that acknowledge the positive impact we have as professionals and individuals within the community we live within.[5] Resiliency is the fuel that builds our emotional intelligence and capacity to preserve our ability to be servant leaders over the long term.

As professional case managers, we need to be cognizant of our obligation to build a legacy that assists the next generation of individuals to effectively execute our important role. CMSA is committed to developing a vision that deploys strategies to strengthen our profession into the future. We value your insight and suggestions on how we can build a stronger community of practice. CM

***Dr Alejandro** is the Director of Care Management at UC Irvine Health and Assistant Professor of Nursing at Mount St. Mary's University in Los Angeles. He serves as a Lieutenant Colonel in the US Army Reserves and is President of the Case Management Society of America.*

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CARF Medical Rehabilitation Director Honored by the American Congress of Rehabilitation Medicine and the American Medical Rehabilitation Providers Association

Chris MacDonell receives both the Coulter Award and the National Leadership Excellence Award

The American Congress of Rehabilitation Medicine (ACRM) awarded Chris MacDonell, CARF International's managing director of medical rehabilitation and international aging services/medical rehabilitation, with the 2019 John Stanley Coulter Award. As the award recipient, Chris presented the award plenary, *An Around the World Perspective: Moving the Needle on Rehabilitation Medicine and Research*, on November 5, 2019, during the opening session of the ACRM Annual Conference in Chicago.

To be named the Coulter Lecturer is to be recognized as one whose professional achievements have contributed significantly to the field of rehabilitation, as did Dr. John Stanley Coulter, former president and treasurer of ACRM. Since 1951, the Coulter Lecture has been a highlight of the annual meeting of ACRM. In 2014, Ms. MacDonell was presented with a Distinguished Member Award and named a Fellow of ACRM. The Distinguished Member Award honors ACRM members who significantly contribute to the development and functioning of ACRM. The Fellow distinction is granted to members who not only demonstrate outstanding professional service to ACRM but also make contributions of national significance to the field of medical rehabilitation.

In a statement about the honors, ACRM said, in part, "Chris has represented CARF International at international, national, regional, and local meetings to promote and interpret standards and the use of accreditation as a quality business and clinical strategy throughout the continuum of care. She is part of the medical rehabilitation team responsible for the training of CARF surveyors and also the development and revision of CARF standards."

Ms. MacDonell was also selected as the sole recipient of the 2019 National Leadership Excellence Award, which was presented to her at the American Medical Rehabilitation Providers Association (AMRPA) Fall Educational Conference & Expo in San Diego, California.

The purpose of the AMRPA National Leadership Excellence Award is to confer association-wide recognition on individuals who have exemplified outstanding service and made significant contributions to the field of medical rehabilitation. These accomplishments contribute to the advancement of the medical rehabilitation field nationally.

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AMRPA Board Chair Richard Kathrins said of the recognition, "You were chosen because you exemplify leadership, integrity, vision, dedication, and excellence in the areas of transformative leadership, life-long service in the field, and advocacy at the state and national levels."

Chris has more than 40 years of experience in the human services field and almost 30 years of experience at CARF International. CM

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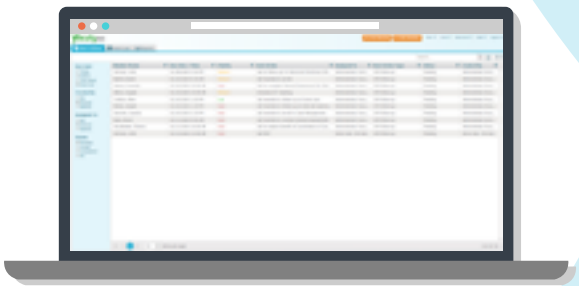

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Protecting Healthcare Workers

By Elizabeth Hogue, Esq.

Concern for healthcare workers in every setting knows no bounds! Providers' imperative is clear: everything possible must be done to keep them safe. Two very insightful physicians, Atul Gawande and Siddartha Mukherjee, have published important articles about protecting healthcare workers. Please read the following:

- "Keeping the Coronavirus from Infecting Health-Care Workers" by Atul Gawande, *The New Yorker*, March 21, 2020.
- "How Does the Coronavirus Behave Inside a Patient?" by Siddhartha Mukherjee, *The New Yorker,* March 26, 2020.

Dr. Gawande points out that 1,300 healthcare workers became infected in Wuhan and that the likelihood of infection was more than 3 times as high as the general population. But Dr. Gawande also points out that transmission to healthcare workers seems to occur primarily through sustained exposure in the absence of basic protection or through the lack of hand hygiene after contact with secretions. He concludes that: "For those who cannot stay home the lesson is that it is feasible to work and stay coronavirus-free, despite the risks."

Dr. Mukherjee asks these important questions: Does a larger viral "dose" result in more severe disease? Can the severity of COVID-19 disease be correlated with the amount of virus to which patients are initially exposed? He says that researchers must begin to address these questions.

In the meanwhile, providers must fulfill their obligations to caregivers with regard to safety. The Occupational Safety and Health Administration (OSHA), for example, has established a general mandate to employers to provide a safe working environment for their employees. So, providers may face OSHA violations when workers can prove that conditions are unsafe.

Likewise, providers owe their employees a duty of reasonable care. That is, they are responsible to take reasonable precautions to protect their employees from harm. This obligation may be far easier to talk about than to fulfill with regard to COVID-19, especially since there is still a great deal that we do not know about transmission of the virus, as Drs. Gawande and Mukherjee point out in their articles. A key question regarding this obligation is: what is reasonable?

Reasonableness is determined by what other providers are doing across the country. In other words, whether providers are taking reasonable precautions to protect workers will be judged by comparison to what others throughout the country would have done under the same or similar circumstances. This definition of reasonableness poses particular difficulty for providers. There is a lack of data or even anecdotal information about how other providers are dealing with protecting workers from harm from COVID-19.

Failure of agencies to fulfill their obligation of reasonable care can be in the form of (1) acts or errors and (2) omissions. In other words, providers must show that nothing happened to harm workers because of something that the providers did or should have done.

Providers will be found to have caused injury to employees if the harm to employees would not have occurred "but for" an act or omission by employers. Courts generally require proof that employees were injured physically in order to compensate them for their injuries. It is likely to be very difficult for caregivers to prove that they contracted COVID-19 on the job, as opposed to exposure outside of their work environments.

Nonetheless, the obligation of all providers is clear. All steps must be taken to protect caregivers. CM

Providers owe their employees a duty of reasonable care. That is, they are responsible to take reasonable precautions to protect their employees from harm. This obligation may be far easier to talk about than to fulfill with regard to COVID-19, especially since there is still a great deal that we do not know about transmission of the virus.

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.*

Nurses on the Front Lines of Coronavirus: Shaved Heads and Adult Diapers!

By Elizabeth Hogue, Esq.

Nurses are undoubtedly on the front lines in the fight against coronavirus. Here are excerpts from a letter that Chinese nurses from Wuhan sent to *The Lancet:*

The conditions and environment here in Wuhan are more difficult and extreme than we could ever have imagined... Due to the need for frequent hand washing, several of our colleagues' hands are covered in painful rashes. As a result of wearing an N95 respirator for extended periods of time and layers of protective equipment, some nurses now have pressure ulcers on their ears and foreheads....In order to save energy and the time it takes to put on and take off protective clothing, we avoid eating and drinking for two hours before entering the isolation ward. Often, nurses' mouths are covered in blisters. Some nurses have fainted due to hypoglycaemia and hypoxia...In addition to the physical exhaustion, we are also suffering psychologically. While we are professional nurses, we are also human. Like everyone else, we feel helplessness, anxiety, and fear...

In an article in *The New York Times* on February 26, 2020, entitled "Shaved Heads, Adult Diapers: Life as a Nurse in the Coronavirus Outbreak," Nurse Zhang Wendan reports that she has cut her hair short for personal hygiene and convenience. Chinese state media has called female medical workers who shave their heads "the most beautiful warriors" fighting the outbreak. Ms. Zhang says that it's difficult to find time during the day to go to the bathroom, let alone deal with menstruation while wearing full-body protective suits, so nurses are wearing adult diapers during their shifts! She says: "I worry about being infected, I miss home." Her mother cooks meals for her and leaves them on the sidewalk outside her home where Ms. Zhang picks them up. Her mother watches her do so from a safe distance.

There you have it: reports from the current front lines!

The predictions were correct, and the virus has spread around the world, including the United States. Nurses everywhere are on the front lines helping patients. Our gratitude to nurses everywhere knows no bounds! 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.*

CCMC New World SYMPOSIUM® 2020

REACHING NEW HEIGHTS

Highlights from CCMC's New World Symposium 2020

By Jennifer Maybin, *Executive Editor,* CareManagement

Hundreds of case managers attended the March 12–14, 2020, New World Symposium in Aurora, Colorado, last month in a handshake- and hug-free environment. Attendance included case managers who joined in person and also those who joined from all over the country for sessions that were offered virtually.

Both MaryBeth Kurland, CAE, CEO, of CCMC, and Michelle Baker, BS, RN, CRRN, CCM, Chair of CCMC, welcomed attendees and offered opening remarks.

Shortly thereafter, Speaker David Glickman, CSP, CPAE, got attendees laughing with his session on work-life balance titled, "What's So Funny About Case Management?" Chikita Mann, MSN, RN, CCM, delivered an ethics session on "Empathy and Compassion: Do You Have It?," explaining how these two soft skills can greatly impact health outcomes through improved communication with clients and other health care providers.

> **The single most impactful experience I had while at the Symposium was the information and knowledge I gained through the various presentations. There was great networking, and I enjoyed the knowledge sharing.**

Addressing the challenges of client motivation was Joyce Cohen, RN, MSW, LCSW-CO. She outlined four keys to igniting drive-in clients with chronic conditions. A second ethics session by Benjamin Miller, PsyD, focused on the problems of drugs, alcohol, and suicide in our nation, which affect not just those who die but those who are left behind.

The CCMC booth was the central hub for networking, with the CCMC team on hand to chat about how to Get Certified, Stay Certified, and Develop Others.

There's no better place than the Symposium to connect with peers from across the healthcare continuum!

Speaker Erin Rhatigan captivated the audience as she shared a very personal story during her session Disaster Case Management.

The Exhibit Hall opened for 2 days, starting on March 12th. Some 60+ exhibiting companies shared their expertise in products and services geared toward case managers. And attendees played some games with the exhibitors, including Passport 2 Prizes and Golden Ticket.

Friday's presenters gave the following talks:

- *Improving Outcomes with Data and Technology,* an industry-sponsored breakfast session by Encompass Health
- *From the Trenches: The Case Manager's Perspective on Implementing an Improved Process for Care Coordination,* delivered by Judith Kepes, RN, CCM
- *Protecting Your License in the Age of Cannabis,* an ethics presentation by Lynn Muller, JD, BA-HCM, CCM
- *Transitional Care: Social Determinants of Health,* presented by Toni Heer, MS, CNS, RN, CMC, CCCTM
- *Disaster Case Management,* presented by Erin Rhatigan, RN, BSN, CCM, who survived the Paradise, Calif. fire

continues on page 40

"The overall tone of commitment to caring for vulnerable populations and the dedication to innovation and strategic planning to meet the needs of those served beyond the walls of the hospital was very impactful."

David Glickman kicked off the Symposium with an entertaining and inspirational session to remind us to find the humor in everyday situations.

The Exhibit Hall was THE place to connect as attendees networked with exhibitors to learn about new products and services!

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CE 1

The CCM Credential: Three Decades of Research to Support Certification

MaryBeth Kurland, CAE, and **Vivian Campagna, MSN, RN-BC, CCM,** *Commission for Case Manager Certification*

More than 48,000 professional case managers today hold the Certified Case Manager® (CCM®) credential. In total, over the past 28 years, more than 80,000 case managers have earned the CCM. This is tremendous growth, given that only 3 decades ago case management was a new practice.

During this time, the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies case managers, has tracked the evolution of professional case management practice. This involves conducting rigorous, scientific research and using the findings to define the scope of case management practice and inform the content of the certification examination.

On its own, each role and function study is important and informative. When seen as a continuum, this research becomes even more impactful. What emerges is a portrait of the dynamic practice of case management as it adapts and responds to changes in health care.

A Look Back to the Beginning

Thirty years ago, case management was an emerging area. From those earliest days, establishing certification was a top priority for setting standards of practice and, most important, protecting consumers. As CCMC describes its founding: "A paramount concern was the varied training and background of people who called themselves case managers; incompetent practice could damage the emerging profession and endanger the well-being of patients. The idea was put forward that case management professionals themselves, rather than a regulatory authority, should oversee the credentialing process."

Establishing a case management credential involved multiple meetings and discussions among health care stakeholders. Then, in July 1992, a task force was convened to finalize the definition of case management—an important step on the road toward establishing certification for professional case managers. The goal of the certification examination was to set a threshold for the level of competency needed to practice case management.

A year later, in June 1993, the first test was administered to the inaugural class of CCMs. (Among the members of that inaugural class was one of the coauthors of this article, Vivian Campagna.) In all, about 10,000 people took the CCM certification examination in 2 test cycles in 1993. Many who came to the field of case management hailed from different backgrounds. Today, the CCM applies cross-setting and cross-discipline in health care and related fields. It is widely recognized as standing for excellence, evidence-based practice, relevance, and rigor.

Those who have practiced case management for many years have witnessed the growth in certification, which was first required by insurance companies and in acute care and then across multiple practice settings. Today, case management is acknowledged to be a specialty practice within health and human services. Wherever they practice, case managers are playing a crucial role in assuring that individuals and their support systems receive the effective and efficient care and resources they need, as appropriate.

Case Management in Perspective

To fully appreciate how case management has changed over the years, and how these changes have been captured in the role and function surveys (also known as job task or practice analyses), it is important to establish a baseline of understanding. CCMC, in its Code of Professional Conduct, defines the practice of case management as "a professional and collaborative process

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Vivian Campagna, MSN, RN-BC, CCM, *is the chief industry relations officer for the CCMC. Vivian has been involved in case management for more than 25 years and has been a volunteer for the Commission in various capacities, including as Chair, before joining in a staff role.*

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that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care." In more recent years, the pursuit of the Triple Aim has been further enhanced by another goal: improving the experience of clinicians and health care providers and ensuring the well-being of the care team. Together, they form the "quadruple aim" that spans the spectrum of providing care for individuals and their support systems as well as caring for providers.

At the heart of case management practice is advocacy, as an underlying value. No matter how much case management has evolved and changed as a specialty practice over the years, the role of the case manager as an advocate remains a constant. In fact, advocacy uniquely defines the case management role, particularly within the complex and fragmented environment of health care delivery.

Professional case managers advocate for individuals (the "clients" who receive case management services, often known as "patients" in many settings) as well as their families/support systems. As advocates, professional case managers—and particularly those who are board-certified as CCMs—have the ethical obligation to pursue the health goals as established by the individual and/or their family/support system.

Advocating for clients is second nature for case managers. Another component of advocacy, however, is educating and empowering individuals to advocate for themselves. As many case managers can undoubtedly attest, there are frequent encounters with individuals and caregivers who, perhaps out of intimidation, lack of knowledge, fatigue or frustration, don't want to speak on their own behalf. By taking a person-centric approach, case managers engage with patients, meeting them where they are and helping them navigate an increasingly complex system. This is helping fuel an information- and engagement-focused evolution in health care.

Today, advocacy is embedded in all 9 phases of the case management process through which case managers provide care to their clients: screening, assessing, stratifying risk, planning, implementing (care coordination), following up, transitioning (transitional care), communicating posttransition, and evaluating. As CCMC's Case Management Body of Knowledge® (CMBOK) states, "The process is iterative, non-linear, and cyclical, its phases being revisited as necessary until the desired outcome is achieved. It also is affected by the care setting where the client and the client's support system are being cared for and the practice setting of the case manager."

Care coordination, which is part of the "implementing" phase, is integral to professional case management; as such, it is best performed by a certified professional who has the education, experience, and requisite knowledge to provide access to the right care and treatment resources, at the right time and in the right setting.

An increased focus on care coordination has emerged in case management practice over the past several years. For example, the 2014 CCMC Role and Function Study found that, across health and human services, professional case managers on interdisciplinary teams were responsible for care management, care coordination, and transitions of care activities. In addition, and of noted importance, these responsibilities raised the expectations that professional case managers would be the ones to undertake quality measurement and evaluation of the systems of care delivery and their impact on patients' care outcomes and their experience of care. Such findings highlight the importance of regularly conducting role and function studies to identify emerging trends and ensure the relevance of how competent practice is defined and understood.

The Role and Function Study: A Brief Overview

CCMC has conducted role and function studies every 5 years, starting in 1994 and continuing in 1999, 2004, 2009, 2014, and 2019 (the latest survey). Each of the surveys has illustrated the current and

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continuously evolving demands being placed on professional case managers. These demands further underscore the importance of the professional case manager's credentials, including educational background, experience, and certification. Certification allows professional case managers to demonstrate that they have the knowledge and skills to competently and effectively perform the day-to-day tasks associated with case management practice.

A key component of earning a credential is the certification examination. The examination content must be relevant, evidence-based, meaningful, and substantiated by current practice. That's why the certification examination development process requires a rigorous, scientifically valid role and function study be conducted on a regular basis. (The 2019 CCM Role and Function Study and its results are described in detail in 2 upcoming articles in *Professional Case Management:* "Understanding the Increasing Role and Value of the Professional Case Manager: A National Study from the Commission for Case Manager Certification, Part I" to be published in the May/June 2020 issue and "The Evolving Role of the Professional Case Manager: A National Study from the Commission for Case Manager Certification, Part II" to be published in the July/August 2020 issue.) The process is summarized here.

The most recent role and function study began in January 2019 with a project planning meeting, after which the members of a subject matter experts taskforce were selected. These experts came from various regions around the United States and represented diverse practice settings of case management, professional disciplines, and educational backgrounds as well as different types of client populations served by case managers.

A draft survey instrument was developed, based on previous instruments used by CCMC in prior role and function studies, expert opinion, and a select review of recent relevant literature. This became the basis from which subject matter experts could begin their work. It was agreed that the 6 essential activity and 5 knowledge domains from the 2014 role and function study be maintained in the 2019 survey, but with updates of items and the structure of these domains. Survey rating scales and demographic questions were also discussed and revised as needed.

The survey instrument was prepared for a pilot test involving 18 professional case managers, also from diverse practice settings and professional disciplines. The purpose of the pilot test was to review the survey instrument for relevance, completeness, and clarity, while allowing pilot test members to offer any suggestions for revision, as needed. The survey was then revised and finalized.

The final survey instrument for the 2019 role and function study contained 5 sections:

1. Background and demographic questions
2. Essential activities, specifically to rate the importance and frequency of essential activity statements in the survey
3. Knowledge and skill domains, also rated for importance and frequency
4. Domain comprehensiveness and test content recommendations
5. Other comments, such as how survey respondents expect their work role to change over the next 5 years, what tasks will be performed, and what knowledge will be needed as the practice changes.

The role and function survey instrument was disseminated to nearly 60,000 professional case managers. Responses were received from a sufficient number of case managers to yield statistically significant results. The responses were analyzed using widely accepted means and methods. (Complete results are reported in the May/June and July/August issues of *Professional Case Management.)*

The Professional Case Manager in the Spotlight

What emerged from the 2019 role and function study is growing evidence of the importance of the professional case manager, particularly as cost-effectiveness, safety, and quality become even greater priorities across the health and human services spectrum. Said another way, as greater emphasis is placed

on the *value of care*—the outcomes achieved compared with the cost of achieving those outcomes—the case manager will be relied on increasingly to evaluate all aspects of those outcomes: clinical, financial, and patient safety and satisfaction.

Hand-in-hand with greater reliance on professional case managers is the need to attest to the competence of case managers. As stated in previous role and function study articles, competent case management practice is defined by the essential activities and knowledge domains. Thus, a virtuous circle forms: from the rigor of field research to validate certification examination content to the certification examination to determine competence of professional case managers.

Over the years, employers have sought case managers who were certified; in time, it became a requirement for employment. Both the 2014 and 2019 role and function studies found that approximately 40% of employers require certification as a condition of employment. With more emphasis being placed on patient-centered care, care coordination, care/case management, and care transition, the increasing percentage of employers requiring certification is not surprising. As the practice of case management grows and changes, gathering more allied disciplines under its broad umbrella of advocacy, certification will continue to play a central role. Within our industry, the CCM credential is widely recognized as the gold standard.

There is a clear case to be made for certification. Health and human services organizations need well-trained and knowledgeable professional case managers. The benefits of certification are numerous, as the CCMC has found:

- Most CCMs earn more than $80,000 annually, and salaries have trended upward for more than 5 years. This compares favorably with median salaries for nurses and social workers, the professional backgrounds of most case managers.
- 88% of CCMs report that certification has had a positive impact on their careers.
- 94% have recommended the CCM credential to other case managers.
- CCMs seek certification to improve employment options, advance professional standing, and enhance personal growth.

These are strong "selling points" for the credential to professional case managers who want to distinguish themselves, their knowledge, and professionalism. There is also a deeper reason why certifications such as the CCM exist: the obligation to protect consumers.

A Look to the Future

The future of case management, without question, will be dynamic. Within health and human services, we are seeing profound changes, including an aging population, projected greater incidence of chronic conditions and comorbidities, and an increased need for care coordination in pursuit of value-based care. Case management has emerged as a vital means of addressing and responding to these trends.

Greater demand for case managers, however, runs contrary to projected shortages of health and human services professionals, particularly as the current generation reaches retirement age. For example, the projected nursing shortage has made it evident that the future demand for case managers cannot be met solely by nurse case managers, though nursing remains the largest professional demographic among practicing case managers today. And although there are an increasing number of social workers and other allied health professionals working in the specialty practice of case management, there is still a great need to continue to draw professionals from across the health and human services spectrum. Case managers do not abandon their professional backgrounds or licensure; rather, case management practice and the pursuit of certification are professional enhancements.

CCMC has set a priority to help promote greater professional diversity among case managers across all work/care settings. This is not meant to diminish the importance of any one profession over another. Rather, it reflects the reality that case management is an interdisciplinary field, spanning health and human services. Greater professional diversity and a pipeline of qualified individuals are essential in developing a vibrant and robust workforce of the future.

A cornerstone of CCMC's strategy is reaching a larger population of professionals who are involved in the case management process. For example, CCMC and the National Association of Social Workers are collaborating to offer eligible social workers the opportunity to become CCMs. This collaboration has contributed to an increase in the percentage of CCMs who have a social work background. In addition, CCMC and the Case Management Society of America (CMSA) are working together on case manager professional development to support CCM certification and CMSA membership.

By attracting more professionals from multiple disciplines and varied practice settings, the CCM credential demonstrates that it is a comprehensive certification for validating competence and supporting ethical practice. Thus, the CCM creates common ground within a community of professionals from nursing, social work, and other health professions who have the requisite knowledge and can competently perform the essential activities of case management.

Looking ahead, we must also reflect on how case managers learn and develop their skills. Consistently, over the past several role and function studies, case managers have reported learning largely on the job. There remains a clear need for more formal academic training. In addition, organizations such as CCMC must continue to advance professional development offerings, including continuing education, for the maintenance and renewal of certification.

In addition, much can be done by individual case managers. As noted in previous CCMC columns in this publication, mentoring is essential to case management for the development of professionals who come from a variety of disciplines. Mentoring supports and facilitates the on-the-job learning that enables case managers to gain the knowledge and skills required for today's practice. This is a call to action to the current generation of professional case managers. The need is great, and the opportunities are ample for them to pass along their knowledge to help ensure a qualified workforce exists to handle the demands of case management practice in the future.

What case managers need to know, both now and in the future, will be identified and evaluated through ongoing field surveys. Only by routinely surveying case managers across the field—in every practice/care setting—can the profession capture the most current definition of what it means to be competent in case management practice. The results of each successive role and function study establish the blueprint for the practice and inform the content for the certification examination. CCMC is proud of its legacy of a research-backed certification and a deep ongoing commitment to the practice of professional case management. **CE 1**

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CE II

Projecting the Future of Case Management in the 22nd Century

Melanie A. Prince, MSN, RN, NE-BC, CCM

Case management dates back nearly a century; the practice of case management originated from the need to assist people with chronic illness, especially psychiatric disorders.[1] Social workers were best positioned to provide community-based care coordination and over the last 5 decades, other disciplines, primarily nursing, have evolved to coordinate services, manage care delivery, and navigate ever-changing health care systems. Variability and sometimes ambiguity of the term case management continue to persist, but case management organizations and publications are coalescing around common descriptors to define case management practice today.

While it is impossible to cite the myriad of references and definitions for case management here, 2 national certifying bodies for case management practice define knowledge domains and scope of services that represent common elements associated with case management practice. The Commission for Case Manager Certification (CCMC), governing body for the Certified Case Manager (CCM) credential, describes 5 knowledge domains for case management practice: care delivery and reimbursement methods; psychosocial concepts and support systems; quality and outcomes evaluation and measurements; rehabilitation concepts and strategies; and ethical, legal, and practice standards.[2] The National Board for Case Management.™ (NCBM), governing body for the Accredited Case Manager (ACM) credential, defines case management scope of services as care coordination, education, utilization management, transition management, and compliance.[3,4] While the knowledge domains and scope of services for certification and accreditation use different nomenclatures, a closer review of both reveals clear parallels (Table 1).

TABLE 1 CERTIFIED CASE MANAGEMENT KNOWLEDGE DOMAINS AND ACCREDITED CASE MANAGER SCOPE OF SERVICES

Certified Case Management Knowledge Domains	Accredited Case Manager Scope of Services
Care delivery and reimbursement methods	Care coordination
Psychosocial concepts and support systems	Education
Quality/outcomes evaluation and measurements	Utilization management
Rehabilitation concepts and strategies	Transition management
Ethical, legal, and practice standards	Compliance

The totality of principles and concepts depicted in the CCM knowledge domains and ACM scopes of practice is a good lens from which to peer into the future of case management. Assume that future generations of case managers will maintain practice norms that include the previously cited knowledge domains and scopes of practice. One way to view the future of case management is by predicting the ability to provide case management in an evolving context around 1) demography and humanity, 2) implementing policy, 3) emerging technologies, 4) responding to social and cultural influences, and 5) paying for health care.

These 5 contextual areas would require case managers to practice within the domains and scopes as described above, but they are also key areas of the future environment that will impact the preparedness and ability of case managers to thrive. Assume the future spans the years 2020–2100. How can one predict the knowledge, skills, and abilities required to practice case management differently yet effectively?

Demography and Humanity interpret

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statistics that reflect how human populations change over time as a result of births, deaths, aging, and geographical migration.[5] Key statistics that influence specific populations are fertility, mortality, and migration rates.[5] For example, the United Nations (UN) projects an increase in births in the United States after a significant decline between 2000 and 2020, at 13 per one thousand annually by 2021.[5] The UN also projects an increase in the number of deaths per year at approximately 4.6 million by 2021, a steady increase since 2000 (Figure 1).[5] The projections indicate more people will die rather than be born each year. The life expectancy for people who are born in 2020 will steadily rise from approximately 78 to 88 years (Figure 2).[5] Additionally, consider that migration trends are projected to be flat in the years 2020 and beyond, which is reflected in the rate of population change. Figure 3 depicts population change influenced by births, deaths and migration. What are the implications for the future of case management?

Individual, community-based, and hospital case management has already evolved to population health management either by disease states, geographical cohorts, beneficiary groups, or a combination of the three. An understanding of births, deaths, and migration projections combined with initiatives currently under development will position case management as a responsive specialty that may influence said projections. For example, to anticipate care delivery, psychosocial support systems, and outcomes evaluation, case managers can reference initiatives such as the Healthy People 2030 plan to guide education, skills development, and interprofessional collaborations. Healthy People 2030 goals are centered around disease and premature death prevention, health disparities,

FIGURE 1 **US: AVERAGE NUMBER OF BIRTHS AND DEATHS**

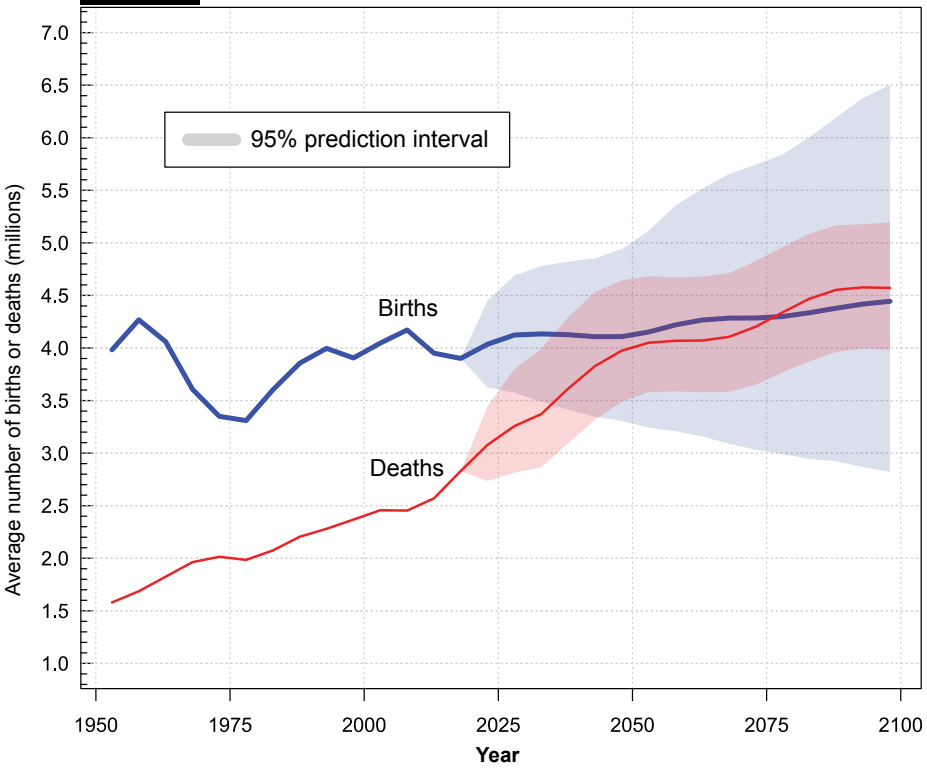


FIGURE 2 **LIFE EXPECTANCY AT BIRTH (both sexes combined)**

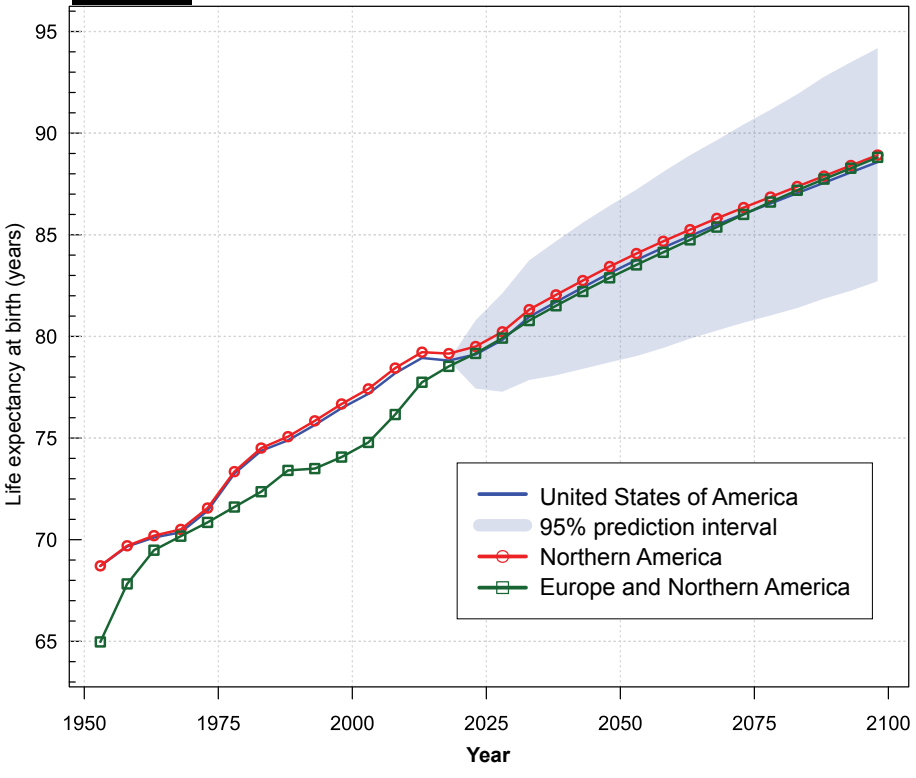


FIGURE 3 **AVERAGE ANNUAL RATE OF POPULATION CHANGE**

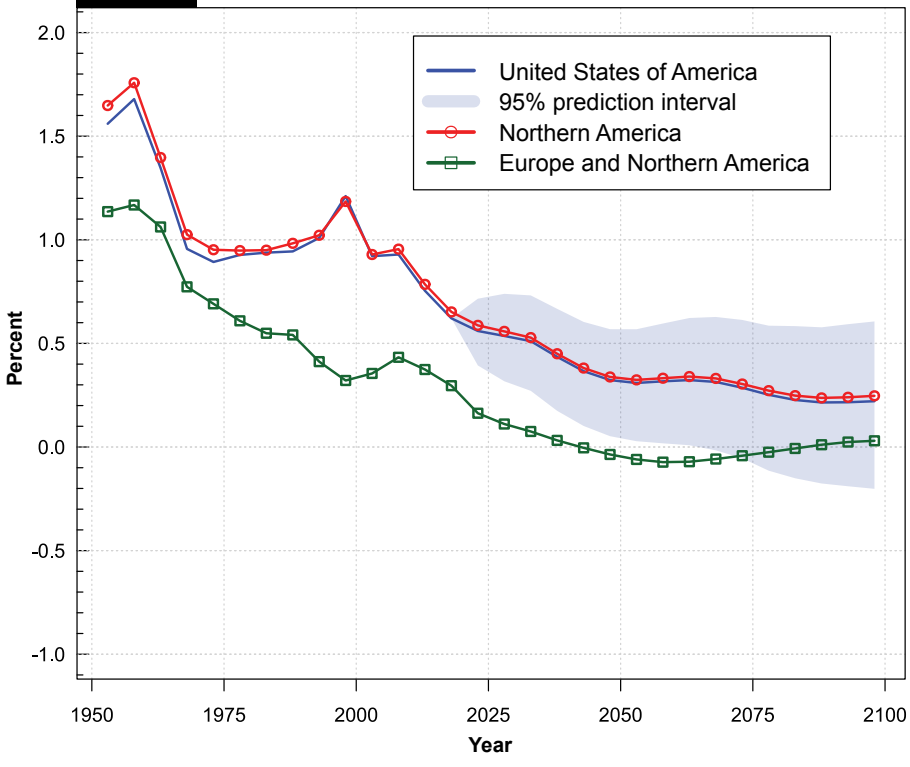


TABLE 2 **AMA INTEREST ITEMS**

AMA Interest Item	Case Management Domain or Scope of Practice
Ban on Medicare Advantage "no cause" network terminations	Care coordination utilization management
Safe and efficient e-prescribing	Transition management
Assuring patient access to kidney transplantation	Rehabilitation strategies transition management
Pharmacy benefit managers	Reimbursement methods utilization management
Study of confidentiality and privacy protection	Ethical and legal standards compliance
Extending Medicaid coverage to 12 months postpartum	Psychosocial concepts and support systems
COPD National Action Plan	Quality and outcomes evaluation and measures
Direct-to-consumer genetic tests	Education

Abbreviations: AMA, American Medical Association; COPD, chronic obstructive pulmonary disease.

and policies to improve health and well-being.[6]

Implementing Policy written by federal, state, and local governments as well as national organizations that produce evidenced-based guidelines is another area to study as a way to predict the future environment for case management. A recent policy change by the Centers for Medicare & Medicaid Services (CMS) is a good example of how policy can impact the way in which case managers operate within the domains and scope of care context. CMS will now cover approved tools and tests for patients with breast and ovarian cancer. Diagnostic procedures such as next-generation sequencing (NGS) will provide a complete profile of a patient's cancer cells and support a more precise and tailored care plan. CMS Administrator Seema Verma stated "We recognize that cancer patients shoulder a heavy burden, so we're leaving no stone unturned in supporting women's health and getting all patients the care they need. NGS testing provides clinically valuable information to guide patients and physicians in developing a personalized treatment plan."[7] Case managers are intimately and expansively engaged with patients and families coping with cancer care. A policy such as NGS approval will influence case load, reimbursement, collaborative care in population health management, social determinants of health considerations, and health literacy, a key factor in case managers' ability to drive clients toward self-care management.

Case management leaders of the future should boldly forge alliances with other professionals who develop and codify policies throughout the health care industry. Contemplate a future where case management professionals are consultants or advisors to the many governance committees, councils, special groups, or House of Delegates of the American Medical Association (AMA). Many policy proposals produced by the AMA are either influenced or implemented by case management. Imagine providing input as an end user of policies around the following list of AMA interest items (Table 2).[8]

The AMA is an important and significant developer of policy

Case management leaders of the future should boldly forge alliances with other professionals who develop and codify policies throughout the health care industry. Contemplate a future where case management professionals are consultants or advisors to the many governance committees, councils, special groups, or House of Delegates of the American Medical Association (AMA).

including positions on innovation and emerging technologies (eg, augmenting treatment regimens with artificial intelligence in health care).

Emerging Technologies are poised to deliver convenience, accuracy, and efficiency for both consumers and providers of health care. But technology produces both excitement and anxiety for users of tools, computers, applications, social media platforms, and robotics. Whether elation or dread, case managers must embrace new knowledge and place themselves in a continuous learning loop for technical skills that are perishable after a few years, as technology continues to evolve and expand. Let's take a look at the case manager's knowledge domains and scope of care that may employ emerging technologies. If there is an entity listed in the following table, consider what case managers must do today to prepare for tomorrow (Table 3).

TABLE 3 CCM KNOWLEDGE DOMAINS, ACM SCOPE OF SERVICES, AND EMERGING TOOLS AND TECHNOLOGIES

CCM Knowledge Domains	ACM Scope of Services	Emerging Tools and Technologies
Care delivery and reimbursement methods	Care coordination	• Crowd sourcing • Digitally connected care • Value-based purchasing • Pay for performance reimbursement • Cash app, Venmo for cash-on-demand payments • Virtual visits online (Teladoc)
Psychosocial concepts and support systems	Education	• Talkspace online therapy • Text-based therapy • Artificial intelligence
Quality and outcomes evaluation and measurements	Utilization management	• Smart apps collaborative care • Telehealth remote monitoring • Implantable devices • Interoperability of big data sets and systems
Rehabilitation concepts and strategies	Transition management	• Postsurgical rehab apps • Exoskeletons • Robotics
Ethical, legal, and practice standards	Compliance	• Digital health data • Cybersecurity and privacy • Health care clouds

Abbreviation: CCM, certified case manager.
Note. Author does not endorse nor have a financial interest in any companies or products listed in Table 3.

Case managers must not only become proficient in knowledge and use of emerging technologies but also should anticipate the second-order effects of technological advances. Second-order effects or unintentional consequences may arise in the form of reductions in human labor force, increased health care disparities, reduced health literacy, and cultural attitudes of mistrust. Much of the technological advances will move care from hospitals to home, and case managers must prepare to operate in the "original home (community-based)" environment but in a new way and with an expectation for tolerance without judgment. This is where societal influences will come into play.

Societal and Cultural Influences will play a significant role in how case managers support clients of the future. The "family" unit will continue to be redefined, presenting privacy and accountability considerations for care coordination and psychosocial support. Personal views on religion, nonreligion, dietary practices, hygienic customs, "high-risk" behaviors, newly legalized medicinal uses for "drug" substances, gender identification, and blended cultures will challenge personal beliefs and principles. How will societal attitudes or political positions impact case managers' ability to support clients where they are? For example, predictions for premature deaths are on an upward slope, likely due to injuries and violence. What paths will case managers take when mass

Case management of the future has the potential to drive a transformative change in health economics beyond chronic illness, complex injury, or occupational health cost savings. One way is to make prevention profitable, something that has been elusive to date.

shootings and victims of gun violence intersect with health care delivery and individual beliefs on gun policy? Consider the prediction that even more care will move from hospital to home. Will case managers be comfortable interacting with clients whose home environments are inconsistent with personal beliefs, especially beliefs on best methods to achieve desired health outcomes? I follow Rebekah Fenton, MD, on Twitter and copied one of her quotes on a post-it note for later use. I am unable to cite the original Twitter date, but her comment is worth sharing as openly/publicly sourced content. Dr. Fenton stated, "My job as a doctor doesn't give me the right to evaluate someone's character or decisions; it requires that I support their thriving. As I remember my dear patients, I'm reminded to combat the systems that threaten our patients' health over judging individual actions of a patient." I share this quote because case managers will be faced with emotional, intellectual, and social belief conflicts in clients' decisions to partner with them on care management. This challenge will extend across the developmental life span spectrum. Other issues to ponder are as follows: How will case managers support an aging client population who may distrust advances in technology? Will case managers be effective client advocates and "fight the system" that does not appear to work for disparate or disenfranchised subpopulations? The future will likely not produce a uniform and level playing field for consumers of health care. At the end of the day, money will continue to drive health care decisions, activities, and care management.

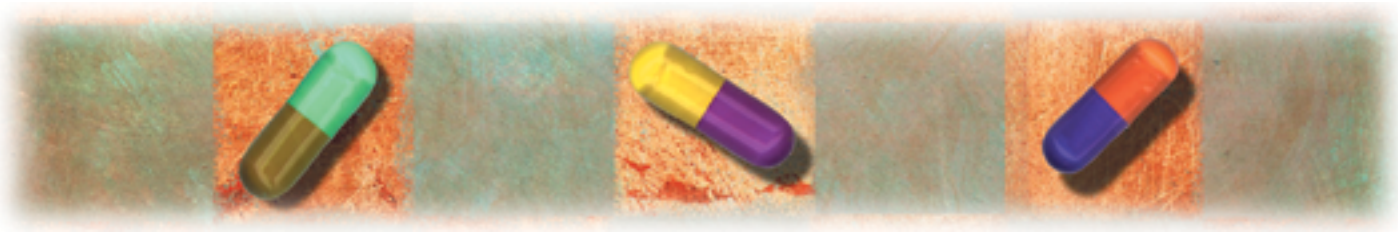
Paying for Health Care will be predictably unpredictable. Today's political discourse has become the DNA of the health care delivery system in America. Who will pay, how will reimbursements occur, and when payment is delivered are questions that currently have a multitude of answers and nonanswers. As of this publication date, many countries are responding to an infectious disease pandemic. A new economic question may be "should I pay?" For example, persons who are at risk of exposure for the illness may be required to undergo diagnostic testing and/or an inpatient stay for care that they may not have otherwise sought. However, United States public health laws and governmental guidelines mandate protection of the community at large regardless of an individual's ability to pay for testing and care. Should the individual pay for care they did not seek or should the government absorb the costs? Is the consumer or the government the final decision maker?

Going forward, will consumer-based practices evolve to a new series of patients' rights? Envision the year 2100, where clients input their symptoms, care needs, socioeconomic status, radius to medical facility, teledoc consultation, smart home device research, bank account information, and technological capabilities into an artificial intelligence apparatus that will produce a menu of care options and associated costs. Case managers must be prepared to potentially relinquish control over client adherence to the case manager's care plan or resource recommendations and focus more on consequences of predetermined client decisions. In other words, the case manager of the future may be on the receiving end of a client-designed care plan and the new advocacy role may involve steering the care management in a way that achieves consumer-desired outcomes that are balanced with best economic value for the supporting delivery system.

Case management of the future has the potential to drive a transformative change in health economics beyond chronic illness, complex injury, or occupational health cost savings. One way is to make prevention profitable, something that has been elusive to date. For example, can case managers neutralize the impact of poverty and rurality on increased health costs, care utilization, and negative health outcomes? The case management knowledge domains and scope of care as described in Table 1 will continue to be relevant in the coming years. Future considerations are the contextual field in which case managers will apply these principles. Predictive changes in demography, US policy, emerging technologies, evolving social and cultural influences, and health care economics will force case managers to answer a central question. Should the

continues on page 41

PharmaFacts for Case Managers



Nurtec ODT (rimegepant) orally disintegrating tablets, for sublingual or oral use

INDICATIONS AND USAGE

Nurtec ODT is indicated for the acute treatment of migraine with or without aura in adults.

Limitations of Use

Nurtec ODT is not indicated for the preventive treatment of migraine.

DOSAGE AND ADMINISTRATION

Dosing Information

The recommended dose of Nurtec ODT is 75 mg taken orally. The maximum dose in a 24-hour period is 75 mg. The safety of treating more than 15 migraines in a 30-day period has not been established.

Administration Information

Instruct the patient on the following administration instructions:

- Use dry hands when opening the blister pack.
- Peel back the foil covering of one blister and gently remove the orally disintegrating tablet (ODT). Do not push the ODT through the foil.
- As soon as the blister is opened, remove the ODT and place on the tongue; alternatively, the ODT may be placed under the tongue.
- The ODT will disintegrate in saliva so that it can be swallowed without additional liquid.
- Take the ODT immediately after opening the blister pack. Do not store the ODT outside the blister pack for future use.

DOSAGE FORMS AND STRENGTHS

Orally disintegrating tablets: white to off-white, circular, and debossed with the symbol, each containing 75 mg of rimegepant.

CONTRAINDICATIONS

Nurtec ODT is contraindicated in patients with a history of hypersensitivity reaction to rimegepant, Nurtec ODT, or any of its components. Delayed serious hypersensitivity has occurred.

WARNING AND PRECAUTIONS

Hypersensitivity Reactions

Hypersensitivity reactions, including dyspnea and rash, have occurred with Nurtec ODT in clinical studies. Hypersensitivity reactions can occur days after administration, and delayed serious hypersensitivity has occurred. If a hypersensitivity reaction occurs, discontinue Nurtec ODT and initiate appropriate therapy.

ADVERSE REACTIONS

The following clinically significant adverse reactions are discussed in greater detail in the prescribing information:

- Hypersensitivity Reactions

USE IN SPECIFIC POPULATIONS

Pregnancy Risk Summary

There are no adequate data on the developmental risk associated with the use of Nurtec ODT in pregnant women. In animal studies, oral administration of rimegepant during organogenesis resulted in adverse effects on development in rats (decreased fetal body weight and increased incidence of fetal variations) at exposures greater than those used clinically and which were associated with maternal toxicity. The evaluation of developmental effects following oral administration of rimegepant throughout pregnancy and lactation was inadequate. 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. The estimated rate of major birth defects (2.2 to 2.9%) and miscarriage (17%) among deliveries to women with migraine are similar to rates reported in women without migraine.

Data

Animal Data

Oral administration of rimegepant (0, 10, 60, or 300 mg/kg/day) to pregnant rats during the period of organogenesis resulted in decreased fetal body weight and an increased incidence of fetal variations at the highest dose tested (300 mg/kg/day), which was associated with maternal toxicity. Plasma exposures (AUC) at the no-effect dose (60 mg/kg/day) for adverse effects on embryofetal development were approximately 45 times that in humans at the maximum recommended human dose (MRHD) of 75 mg/day. Oral administration of rimegepant (0, 10, 25, or 50 mg/kg/day) to pregnant rabbits during the period of organogenesis resulted in

no adverse effects on embryofetal development. The highest dose tested (50 mg/kg/day) was associated with plasma exposures (AUC) approximately 10 times that in humans at the MRHD. The prenatal and postnatal development study in rats, in which rimegepant (0, 10, 25, or 60 mg/kg/day) was orally administered throughout gestation and lactation, was inadequate to assess for adverse effects of rimegepant during these periods of development.

Lactation

There are no data on the presence of rimegepant or its metabolites in human milk, the effects of rimegepant on the breastfed infant, or the effects of rimegepant on milk production. There are no animal data on the excretion of rimegepant in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Nurtec ODT and any potential adverse effects on the breastfed infant from Nurtec ODT or from the underlying maternal condition

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

In pharmacokinetic studies, no clinically significant pharmacokinetic differences were observed between elderly and younger subjects. Clinical studies of Nurtec ODT did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients.

CLINICAL STUDIES

The efficacy of Nurtec ODT for the acute treatment of migraine with and without aura in adults was demonstrated in a randomized, double-blind, placebo-controlled trial: Study 1 (NCT03461757). The study randomized patients to 75 mg of Nurtec ODT (N=732) or placebo (N=734). Patients were instructed to treat a migraine of moderate to severe headache pain intensity. Rescue medication (i.e., NSAIDs, acetaminophen, and/or an antiemetic) was allowed 2 hours after the initial treatment. Other forms of rescue medication such as triptans were not allowed within 48 hours of initial treatment. Approximately 14% of patients were taking preventive medications for migraine at baseline. None of the patients in Study 1 were on concomitant preventive medication that act on the CGRP pathway.

The primary efficacy analyses were conducted in patients who treated a migraine with moderate to severe pain. Nurtec ODT 75 mg demonstrated an effect on pain freedom and most bothersome symptom (MBS) freedom at two hours after dosing, compared to placebo. Pain freedom was defined as a reduction of moderate or severe headache pain to no headache pain, and MBS freedom was defined as the absence of the self-identified MBS (i.e., photophobia, phonophobia, or nausea). Among patients who selected an MBS, the most commonly selected symptom was photophobia (54%), followed by nausea (28%), and phonophobia (15%). In Study 1, the percentage of patients achieving headache pain freedom and MBS freedom two hours after a single dose was statistically significantly greater in patients who received Nurtec ODT compared to those who received placebo.

In Study 1, statistically significant effects of Nurtec ODT compared to placebo were demonstrated for the additional efficacy endpoints of pain relief at 2 hours, sustained pain freedom 2-48 hours, use of rescue medication within 24 hours, and the percentage of patients reporting normal function at two hours after dosing (Table 2). Pain relief was defined as a reduction in migraine pain from moderate or severe severity to mild or none. The measurement of the percentage of patients reporting normal function at two hours after dosing was derived from a single item questionnaire, asking patients to select one response on a 4-point scale; normal function, mild impairment, severe impairment, or required bedrest.

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Nurtec ODT 75 mg orally disintegrating tablets are white to off-white, circular, debossed with the symbol, and supplied in cartons containing a blister pack of 8 orally disintegrating tablets. Each ODT contains 75 mg of rimegepant.

Storage and Handling

Store Nurtec ODT at controlled room temperature, 20°C to 25°C (68°F to 77°F); with excursions permitted between 15°C to 30°C (59°F to 86°F).

See Product Insert for full prescribing information.

Manufactured for: Biohaven Pharmaceuticals, Inc.

Barhemsys® (amisulpride) injection, for intravenous use

INDICATIONS AND USAGE

Barhemsys® is indicated in adults for:

- prevention of postoperative nausea and vomiting (PONV), either alone or in combination with an antiemetic of a different class.
- treatment of PONV in patients who have received antiemetic prophylaxis with an agent of a different class or have not received prophylaxis.

DOSAGE AND ADMINISTRATION

Recommended Dosage

Prevention of PONV 5 mg as a single intravenous injection infused over 1 to 2 minutes at the time of induction of anesthesia.

Treatment of PONV 10 mg as a single intravenous injection infused over 1 to 2 minutes in the event of nausea and/or vomiting after a surgical procedure.

Preparation and Administration

- Dilution of Barhemsys is not required before administration.

Barhemsys is chemically and physically compatible with Water for Injection, 5% Dextrose Injection and 0.9% Sodium Chloride Injection, which may be used to flush an intravenous line before or after administration of Barhemsys.
- Protect from light. Barhemsys is subject to photodegradation. Administer Barhemsys within 12 hours of removal of the vial from the protective carton.
- Prior to administration, inspect the Barhemsys solution visually for particulate matter and discoloration. Discard if particulate matter or discoloration is observed.

DOSAGE FORMS AND STRENGTHS

Injection: 5 mg/2 mL (2.5 mg/mL) as a clear, colorless sterile solution in a single-dose vial.

CONTRAINDICATIONS

Barhemsys is contraindicated in patients with known hypersensitivity to amisulpride.

WARNINGS AND PRECAUTIONS

QT Prolongation

Barhemsys causes dose- and concentration-dependent prolongation of the QT interval. The recommended dosage is 5 or 10 mg as a single intravenous dose infused over 1 to 2 minutes. Avoid Barhemsys in patients with congenital long QT syndrome and in patients taking droperidol. Electrocardiogram (ECG) monitoring is recommended in patients with pre-existing arrhythmias/cardiac conduction disorders; electrolyte abnormalities (e.g., hypokalemia or hypomagnesemia); congestive heart failure; and in patients taking other medicinal products (e.g., ondansetron) or with other medical conditions known to prolong the QT interval.

ADVERSE REACTIONS

The most common adverse reactions reported in Clinical Trials for Prevention of POVN included: chills, hypokalemia, procedural hypotension, and abdominal distension. The most common adverse reaction for treatment of POVN was injection site pain.

CLINICAL STUDIES

Prevention of Postoperative Nausea and Vomiting

The efficacy of Barhemsys for the prevention of PONV was evaluated in two randomized, double-blind, placebo-controlled, multicenter trials in patients undergoing general anesthesia and elective surgery (Study 1 and Study 2). In Study 1 (NCT01991860), patients received monotherapy with Barhemsys; while in Study 2 (NCT02337062), patients received Barhemsys in combination with one other intravenously administered, non-dopaminergic antiemetic (ondansetron, dexamethasone, or betamethasone). In both trials, patients were administered Barhemsys at the induction of anesthesia. Study 1 was conducted in the United States in 342 patients. The mean age was 54 years (range 21 to 88 years); 65% female; 87% White/Caucasian, 12% Black, and 1% Asian race. The treatment groups were similarly matched in terms of risk for PONV with 30% of patients having two risk factors, 47% of patients having three risk factors, and 23% of patients having four risk factors. Study 2 was conducted in the United States and Europe in 1,147 patients. The mean age was 49 years (range 18 to 91 years); 97% female; 75% White/Caucasian, 9% Black, 1% Asian, and 14% of unreported race. The treatment groups were similarly matched in terms of risk for PONV with 56% of patients having three risk factors and 43% of patients having four risk factors. The primary efficacy endpoint in both trials was Complete Response, defined as absence of any episode of emesis or use of rescue medication within the first 24 hours postoperatively.

Treatment of Postoperative Nausea and Vomiting

The efficacy of Barhemsys 10 mg as a single dose was evaluated in two randomized, double-blind, placebo-controlled, multicenter trials in patients experiencing PONV after general anesthesia and elective surgery (Study 3 and Study 4). Study 3 (NCT02449291) enrolled patients who had not received prior PONV prophylaxis, whereas Study 4 (NCT02646566) included patients who had received and failed PONV prophylaxis with an antiemetic of another class. Patients were excluded if they had received a D2 receptor antagonist antiemetic. Study 3 was conducted in 369 patients (mean age 47 years, range 19 to 82 years; 76% female; 82% White/Caucasian, 8% Black, 2% Asian, and 8% of unreported race). Most of the patients had either two risk factors (36%) or three risk factors (53%) for PONV and these percentages were similar between treatment groups. Study 4 was conducted in 465 patients (mean age 46 years, range 18 to 85 years; 90% female; 82% White/Caucasian, 9% Black, 3% Asian, and 6% of unreported race). Patients had received prior PONV prophylaxis with one or more nondopaminergic antiemetics: a 5-HT3-antagonist in 77%, dexamethasone in 65% and another antiemetic class in 10%. Most of the patients had either three risk factors (43%) or four risk factors (51%) for PONV and these percentages were similar between treatment groups. For both trials, the primary efficacy endpoint was Complete Response defined as absence of any episode of emesis or use of rescue medication within the first 24 hours after treatment (excluding emesis within the first 30 minutes).

HOW SUPPLIED/STORAGE AND HANDLING

Barhemsys (amisulpride) injection is supplied as follows:

Package of 10 cartons. Each carton contains one single-dose vial of clear, colorless, sterile solution of Barhemsys (amisulpride) injection, 5 mg in 2 mL (2.5 mg/mL).

Store vials at 20°C to 25°C (68°F to 77°F). Protect from light. Administer Barhemsys within 12 hours after the vial is removed from the protective carton.

For full prescribing information, see Product Insert. Bahemsys is distributed by Acacia Pharma Inc.

LITSCAN FOR CASE MANAGERS

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AIDS. 2020 Mar 11. doi: 10.1097/QAD.0000000000002517. [Epub ahead of print]

Reported preexposure prophylaxis (PrEP) use among male sex partners of HIV-positive men-2016–2018.

Beer L, Tie Y, Smith DK, et al.

OBJECTIVE: To estimate the proportion of U.S. HIV-positive men who report a male HIV-negative/unknown status (HIV-discordant) sexual partner taking PrEP, and the use of multiple HIV prevention strategies within partnerships.

DESIGN: The Medical Monitoring Project is a complex sample survey of U.S. adults with diagnosed HIV.

METHODS: We used data collected during June 2016-May 2018 among sexually-active HIV-positive men who had ≥1 HIV-discordant male partner (N=1,871) to estimate the weighted prevalence of reporting ≥1 partner taking PrEP. Among HIV-discordant partnerships (N=4,029), we estimated PrEP use, viral suppression among HIV-positive partners, and condomless anal sex. We evaluated significant ($p<0.05$) differences between groups using prevalence ratios with predicted marginal means.

RESULTS: Twenty-eight percent of sexually-active HIV-positive MSM reported ≥ 1 HIV-discordant male partner taking PrEP. Twenty percent of HIV-discordant partners were reported to be taking PrEP; 73% were taking PrEP or the HIV-positive partner was virally suppressed. PrEP use was lower among black and Hispanic partners compared with white partners (12% and 19% vs. 27%). Fewer black than white MSM were in partnerships in which PrEP was used or the HIV-positive partner had sustained viral suppression (69% vs. 77%). Condomless anal intercourse was more prevalent in partnerships involving PrEP use and in partnerships involving either PrEP use or sustained viral suppression among the HIV-positive partner.

CONCLUSIONS: PrEP use was reported among 1 in 5 partners, with disparities between black and white partners. Increasing PrEP use and decreasing racial/ethnic disparities could reduce disparities in HIV incidence and help end the U.S. HIV epidemic.

Ann Intern Med. 2020 Mar 10. doi: 10.7326/M19-3478. [Epub ahead of print]

Comparative pricing of branded tenofovir alafenamide-emtricitabine relative to generic tenofovir disoproxil fumarate-emtricitabine for HIV preexposure prophylaxis: a cost-effectiveness analysis.

Walensky RP, Horn T, McCann NC, et al.

BACKGROUND: Tenofovir alafenamide-emtricitabine (F/TAF) was recently approved as a noninferior and potentially safer option than tenofovir disoproxil fumarate-emtricitabine (F/TDF) for HIV preexposure prophylaxis (PrEP) in the United States.

OBJECTIVE: To estimate the greatest possible clinical benefits and economic savings attributable to the improved safety profile of F/TAF and the maximum price payers should be willing to pay for F/TAF over generic F/TDF.

DESIGN:Cost-effectiveness analysis.

DATA SOURCES: Published literature on F/TDF safety (in persons with and those without HIV) and the cost and quality-of-life effects of fractures and end-stage renal disease (ESRD).

TARGET POPULATION: Age-stratified U.S. men who have sex with men (MSM) using PrEP.

TIME HORIZON: Five years.

PERSPECTIVE: Health care sector.

INTERVENTION: Preexposure prophylaxis with F/TAF versus F/TDF.

OUTCOME MEASURES: Fractures averted, cases of ESRD averted, quality-adjusted life-years (QALYs) saved, costs, incremental cost-effectiveness ratios (ICERs), and maximum justifiable price for F/TAF compared with generic F/TDF.

RESULTS OF BASE-CASE ANALYSIS: Over a 5-year horizon, compared with F/TDF, F/TAF averted 2101 fractures and 25 cases of ESRD for the 123 610 MSM receiving PrEP, with an ICER of more than $7 million per QALY. At a 50% discount for generic F/TDF ($8300 per year) and a societal willingness to pay up to $100 000 per QALY, the maximum fair price for F/TAF

was $8670 per year.

RESULTS OF SENSITIVITY ANALYSIS: Among persons older than 55 years, the ICER for F/TAF remained more than $3 million per QALY and the maximum permissible fair price for F/TAF was $8970 per year. Results were robust to alternative time horizons and PrEP-using population sizes.

LIMITATION: Intermittent use and on-demand PrEP were not considered.

CONCLUSION: In the presence of a generic F/TDF alternative, the improved safety of F/TAF is worth no more than an additional $370 per person per year.

Invest Radiol. 2020 Feb 29. doi: 10.1097/RLI.0000000000000672. [Epub ahead of print]

The clinical and chest CT features associated with severe and critical COVID-19 pneumonia.

Li K, Wu J, Wu F, et al.

OBJECTIVE: To investigate the clinical and CT features associated with severe and critical Corona Virus Disease 2019 (COVID-19) pneumonia.

MATERIALS AND METHODS: Eighty-three patients with COVID-19 pneumonia including 25 severe/critical cases and 58 ordinary cases were enrolled. The chest CT images and clinical data of them were reviewed and compared. The risk factors associated with disease severity were analyzed.

RESULTS: Compared with the ordinary patients, the severe/critical patients had older ages, higher incidence of comorbidities, cough, expectoration, chest pain and dyspnea. The incidences of consolidation, linear opacities, crazy-paving pattern and bronchial wall thickening in severe/critical patients were significantly higher than those of the ordinary patients. Besides, severe/critical patients showed higher incidences of lymph node enlargement, pericardial effusion and pleural effusion than the ordinary patients. The CT scores of severe/critical patients were significantly higher than those of the ordinary patients ($P < 0.001$). Receiver operating characteristic (ROC) curve showed that the sensitivity and specificity of CT Score were 80.0% and 82.8% respectively for the discrimination of the two types. The clinical factors of age > 50 years old, comorbidities, dyspnea, chest pain, cough, expectoration, decreased lymphocytes and increased inflammation indicators were risk factors for severe/critical COVID-19 pneumonia. CT findings of consolidation, linear opacities, crazy-paving pattern, bronchial wall thickening, high CT scores and extrapulmonary lesions were features of severe/critical COVID-19 pneumonia.

CONCLUSIONS: There are significant differences in clinical symptoms, laboratory examinations and CT manifestations between the ordinary patients and the severe/critical patients. Many factors are related to the severity of the disease, which can help clinicians to judge the severity of the patient and evaluate the prognosis.

Lancet Glob Health. 2020 Feb 28. pii: S2214-109X(20)30074-7. doi: 10.1016/S2214-109X(20)30074-7. [Epub ahead of print]

Feasibility of controlling COVID-19 outbreaks by isolation of cases and contacts

Hellewell J, Abbott S, Gimma A, et al.

BACKGROUND: Isolation of cases and contact tracing is used to control outbreaks of infectious diseases, and has been used for coronavirus disease 2019 (COVID-19). Whether this strategy will achieve control depends on characteristics of both the pathogen and the response. Here we use a mathematical model to assess if isolation and contact tracing are able to control onwards transmission from imported cases of COVID-19.

METHODS: We developed a stochastic transmission model, parameterised to the COVID-19 outbreak. We used the model to quantify the potential effectiveness of contact tracing and isolation of cases at controlling a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)-like pathogen. We considered scenarios that varied in the number of initial cases, the basic reproduction number (R0), the delay from symptom onset to isolation, the probability that contacts were traced, the proportion of transmission that occurred before symptom onset, and the proportion of subclinical infections. We assumed isolation prevented all further transmission in the model. Outbreaks were deemed controlled if transmission ended within 12 weeks or before 5000 cases in total. We measured the success of controlling outbreaks using isolation and contact tracing, and quantified the weekly maximum number of cases traced to measure feasibility of public health effort.

FINDINGS: Simulated outbreaks starting with five initial cases, an R0 of 1·5, and 0% transmission before symptom onset could be controlled even with low contact tracing probability; however, the probability of controlling an outbreak decreased with the number of initial cases, when R0 was 2·5 or 3·5 and with more transmission before symptom onset. Across different initial numbers of cases, the majority of scenarios with an R0 of 1·5 were controllable with less than 50% of contacts successfully traced. To control the majority of outbreaks, for R0 of 2·5 more than 70% of

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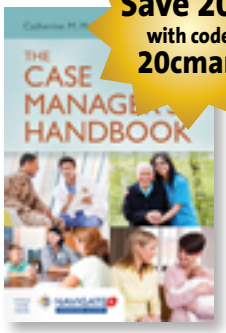

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contacts had to be traced, and for an R0 of 3·5 more than 90% of contacts had to be traced. The delay between symptom onset and isolation had the largest role in determining whether an outbreak was controllable when R0 was 1·5. For R0 values of 2·5 or 3·5, if there were 40 initial cases, contact tracing and isolation were only potentially feasible when less than 1% of transmission occurred before symptom onset.

INTERPRETATION: In most scenarios, highly effective contact tracing and case isolation is enough to control a new outbreak of COVID-19 within 3 months. The probability of control decreases with long delays from symptom onset to isolation, fewer cases ascertained by contact tracing, and increasing transmission before symptoms. This model can be modified to reflect updated transmission characteristics and more specific definitions of outbreak control to assess the potential success of local response efforts.

J Hepatol. 2020 Mar 4. pii: S0168-8278(20)30120-3. doi: 10.1016/j.jhep.2020.02.022. [Epub ahead of print]

Treatment of HCV reduces viral hepatitis-associated liver-related mortality in patients: An ERCHIVES study.

Butt AA, Yan P, Shaikh OS, et al.

BACKGROUND/AIMS: Treating hepatitis C virus (HCV) infection reduces overall mortality and reduces the risk of multiple extrahepatic complications. Whether the reduction in mortality is primarily due to reduction in liver-related causes or extrahepatic complications is unknown.

METHODS: We identified HCV+ persons treated for HCV, and propensity-score matched HCV+/untreated and HCV-uninfected persons in ERCHIVES between 2002-2016. We extracted cause of death data from the National Center for Health Statistics' National Death Index. Viral hepatitis associated liver-related mortality rates among treated and untreated HCV-infected persons were calculated by treatment and attainment of sustained virologic response (SVR).

RESULTS: Among 50,674 HCV+/treated (Group A), 31,749 HCV+/untreated (Group B) and 73,526 HCV-uninfected persons (Group C), 8.6% in Group A, 35.0% in Group B, and 14.3% in Group C died. Among those who died, viral hepatitis associated liver-related mortality rates per 100 patients years [95% CI] were: 0.28[0.27,0.30] for Group A; 1.44 [1.38,1.49] for Group B; and 0.06[0.05,0.06] for Group C; (P<0.0001 for both comparisons). Among HCV+/treated persons, rates were 0.06[0.05,0.06] for those with SVR vs. 0.78[0.74,0.83] for those without SVR. In competing risks Cox proportional hazards analysis, treatment with all-oral DAA regimens (adjusted hazard ratio 0.11[0.09,0.14] and SVR (adjusted hazard ratio 0.10[0.08, 0.11]) were associated with reduced hazards of liver-related mortality.

CONCLUSIONS: Treatment for HCV is associated with a significant reduction in viral hepatitis associated liver-related mortality which is particularly pronounced in those treated with DAA regimens and those who attain SVR. This may account for a significant proportion of reduction in all-cause mortality reported in previous studies.

J Infect Dis. 2020 Mar 11. pii: jiaa109. doi: 10.1093/infdis/jiaa109. [Epub ahead of print]

HCV cure in HIV coinfection dampens inflammation and improves cognition through multiple mechanisms.

Sun B, Abadjian L, Monto A, et al.

BACKGROUND: Chronic inflammation in HIV/HCV coinfection increases cognitive impairment. With newer direct-acting antiviral therapies for HCV, our objective was to determine if chronic inflammation would be decreased and cognition improved with HCV sustained viral response (SVR) in coinfection.

METHODS: We studied 4 groups longitudinally, 7 HCV monoinfected and 12 HIV/HCV coinfected before and after treatment for HCV, 12 HIV monoinfected and 9 healthy controls. We measured monocyte activation and gene expression, monocyte-derived exosome miRNAs expression, plasma inflammation and cognitive impairment before and after therapy.

RESULTS: Plasma sCD163 and neopterin were decreased in HCV mono and coinfected persons. Blood CD16+ monocytes were decreased in coinfection after HCV treatment. Global deficit score improved 25% in coinfection with the visual learning/memory domain the most improved. HCV SVR decreased monocyte interferon genes MX1, IFI27 and CD169 in coinfection and MX1, LGALS3BP and TNFAIP6 in HCV monoinfection. Monocyte exosomes from coinfected persons increased in miR-19a, miR-221 and miR-223, all associated with decreasing inflammation and NF-κB activation.

CONCLUSIONS: HCV cure in coinfection brings monocyte activation to levels of HIV alone. Cognitive impairment is significantly improved with cure but not better than HIV infection alone strongly suggesting that cognitive impairment was driven by both HIV and HCV.

LITSCAN
FOR CASE MANAGERS

J Am Coll Cardiol. 2020 Mar 17;75(10):1178-1195. doi: 10.1016/j.jacc.2019.12.059.

Diuretic therapy for patients with heart failure: JACC state-of-the-art review.

Felker GM, Ellison DH, Mullens W, et al.

Expansion of extracellular fluid volume is central to the pathophysiology of heart failure. Increased extracellular fluid leads to elevated intracardiac filling pressures, resulting in a constellation of signs and symptoms of heart failure referred to as congestion. Loop diuretics are one of the cornerstones of treatments for heart failure, but in contrast to other therapies, robust clinical trial evidence to guide the use of diuretics is sparse. A nuanced understanding of renal physiology and diuretic pharmacokinetics is essential for skillful use of diuretics in the management of heart failure in both the inpatient and outpatient settings. Diuretic resistance, defined as an inadequate quantity of natriuresis despite an adequate diuretic regimen, is a major clinical challenge that generally portends a poor prognosis. In this review, the authors discuss the fundamental mechanisms and physiological principles that underlie the use of diuretic therapy and the available data on the optimal use of diuretics.

Am Heart J. 2019 Dec;218:92-99. doi: 10.1016/j.ahj.2019.09.013. Epub 2019 Oct 20.

Associations between β-blocker therapy and cardiovascular outcomes in patients with diabetes and established cardiovascular disease.

Shavadia JS, Zheng Y, Green JB, et al.

BACKGROUND: The effects of β-blocker therapy in patients with type 2 diabetes (T2D) and established atherosclerotic cardiovascular disease (ASCVD) are unclear. We sought to evaluate associations between β-blocker use in T2D with ASCVD and cardiovascular (CV) outcomes.

METHODS: In patients with T2D and ASCVD enrolled in the Trial Evaluating Cardiovascular Outcomes with Sitagliptin (TECOS), an inverse probability of treatment-weighted Cox proportional hazards model was used to examine the association between baseline β-blocker therapy (at randomization) and the primary CV composite (defined as CV death, non-fatal myocardial infarction [MI], non-fatal stroke, or hospitalization for unstable angina), including in subgroups with prior MI and heart failure (HF); other outcomes evaluated included individual components of the primary composite, hospitalization for HF, and severe hypoglycemic events.

RESULTS: Of the 14,671 patients randomized, 9322 (64%) were on a β-blocker at baseline; these patients were more likely to have prior MI or HF. Over a median 3.0 (25th, 75th percentile: 2.2, 3.6) years, the risk of the primary CV composite was significantly higher with baseline β-blocker use versus no β-blocker use (4.5 vs. 3.4 events/100-patient years, adjusted hazard ratio [HR] 1.17, 95% confidence interval [CI] 1.05-1.29); no significant interaction was noted for patients with versus without prior MI or HF. Baseline β-blocker use was not associated with risks for severe hypoglycemic events (HR 1.14, 95% CI 0.88-1.48).

CONCLUSIONS: In this observational analysis of T2D and ASCVD, baseline β-blocker use was not associated with risks for severe hypoglycemia yet also was not associated with CV risk reduction over 3 years of follow-up, supporting a randomized examination of chronic β-blocker therapy in this patient population.

Transplant Proc. 2019 Dec;51(10):3205-3212. doi: 10.1016/j.transproceed.2019.07.018. Epub 2019 Nov 13.

Geographic disparities in liver allocation and distribution in the United States: where are we now?

Spaggiari M, Okoye O, Tulla K, et al.

BACKGROUND: Equitable deceased donor liver allocation and distribution has remained a heated topic in transplant medicine. Despite the establishment of numerous policies, mixed reports regarding organ allocation persist.

METHODS: Patient data was obtained from the United Network for Organ Sharing liver transplant database between January 2016 and September 2017. A total of 20,190 patients were included in the analysis. Of this number, 8790 transplanted patients had a median Model for End-Stage Liver Disease (MELD) score of 25 (17-33), after a wait time of 129 (32-273) days. Patients were grouped into low MELD and high MELD regions using a score 25 as the cutoff.

RESULTS: Significant differences were noted between low and high MELD regions in ethnicity (white 77.4% vs 60.4%, Hispanic 8.1% vs 24.5%; $P < .001$) and highest level of education (grade school 4.8% vs 8.5%, Associate/Bachelor's degree 19% vs 15.7%, $P < .001$), respectively. Patients in high MELD regions were more likely to be multiply listed if they had a diagnosis of hepatocellular carcinoma (12.1% vs 15%, $P = .046$). Wait-list mortality (4.8% vs 6%, $P < .001$) and wait-list time (110 [27-238] vs 156

[42-309] days, P < .001) were greater in the high MELD regions.

CONCLUSIONS: These results highlight some of the existing disparities in the recently updated allocation and distribution policy of deceased donor livers. Our findings are consistent with previous work and support the liver distribution policy revision.

Am J Obstet Gynecol. 2019 Oct;221(4):318.e1-318.e9. doi: 10.1016/j.ajog.2019.05.024. Epub 2019 May 22.

Assessing endometrial cancer risk among US women: long-term trends using hysterectomy-adjusted analysis.

Doll KM, Winn AN.

BACKGROUND: Commonly reported incidence rates for endometrial cancer fail to take into account both the large number of hysterectomies performed each year and the dynamic change in hysterectomy rate over the past decade. Large racial differences in premenopausal hysterectomy rates between Black and White women in the United States likely affect calculation of race-based risk.

OBJECTIVES: The objectives of the study were to determine how the long-term trends in Black-White differences in endometrial cancer incidence and histology type have changed over time for women at risk.

STUDY DESIGN: Using longitudinal Surveillance, Epidemiology, and End Results data from 1997 to 2014 and state-level hysterectomy prevalence from the Behavioral Risk Factor Surveillance System, we calculated hysterectomy-adjusted incidence rates of endometrial cancer and the proportion of high vs low-risk endometrial cancer, by race, over time.

RESULTS: In women older than 50 years who have not had a hysterectomy, endometrial cancer incidence is 87 per 100,000 from 1997 to 2014. Among White women endometrial cancer incidence changed from 102 (1997-2001) to 86 (2012-2014) cases per 100,000, with a nonsignificant decreasing linear trend (adjusted risk ratio, 0.95; 95% confidence interval, 0.91-1.00; p=0.05). In contrast, incidence for Black women was 88 (1997-2001), 101 (2002-2006), 100 (2007-2011), and 102 (2012-2014) cases per 100,000 with no decreasing trend (adjusted risk ratio, 1.02; 95% confidence interval, 0.96-1.10, P = .449). High-risk histology increased among both groups (White: adjusted risk ratio, 1.06; 95% confidence interval, 1.01-1.11; P = .015; Black: adjusted risk ratio, 1.06; 95% confidence interval, 1.02-1.10, P = .007). Racial difference in the proportion of high-risk disease remained stable.

CONCLUSION: Updated hysterectomy-adjusted incidence demonstrates that endometrial cancer is the second most common cancer among women older than 50 years with a uterus and that endometrial cancer has been more common among Black women compared with White women in the United States since 2002. A clinical approach of proactive communication and routine screening for early symptoms in the perimenopausal and menopausal years, especially among Black women, is warranted. These findings can also inform equitable distribution of research funding for endometrial cancer and serve to promote public awareness of this common cancer.

BMC Pediatr. 2020 Mar 7;20(1):112. doi: 10.1186/s12887-020-2012-7.

Adolescent Interventions to manage self-regulation in type 1 diabetes (AIMS-T1D): randomized control trial study protocol.

Miller AL, Lo SL, Albright D, et al.

Self-regulation (SR), or the capacity to control one's thoughts, emotions, and behaviors in order to achieve a desired goal, shapes health outcomes through many pathways, including supporting adherence to medical treatment regimens. Type 1 Diabetes (T1D) is one specific condition that requires SR to ensure adherence to daily treatment regimens that can be arduous and effortful (e.g., monitoring blood glucose). Adolescents, in particular, have poor adherence to T1D treatment regimens, yet it is essential that they assume increased responsibility for managing their T1D as they approach young adulthood. Adolescence is also a time of rapid changes in SR capacity and thus a compelling period for intervention. Promoting SR among adolescents with T1D may thus be a novel method to improve treatment regimen adherence. The current study tests a behavioral intervention to enhance SR among adolescents with T1D. SR and T1D medical regimen adherence will be examined as primary and secondary outcomes, respectively.

METHODS: We will use a randomized control trial design to test the impact of a behavioral intervention on three SR targets: Executive Functioning (EF), Emotion Regulation (ER), and Future Orientation (FO); and T1D medical regimen adherence. Adolescents with T1D (n = 94) will be recruited from pediatric endocrinology clinics and randomly assigned to treatment or control group. The behavioral intervention consists of working memory training (to enhance EF), biofeedback and relaxation training (to enhance ER), and episodic future thinking training (to enhance FO) across an 8-week period. SR and treatment regimen adherence will be assessed at pre- and post-test using multiple

continues on page 40

CCMC Response to COVID-19: To Our CCM & CDMS Community

To assist our community and protect our staff and volunteers, we are taking several immediate steps that we hope will be helpful to you as you navigate through this difficult time. Given the fluidity of the situation, we will keep you apprised of any additional modifications that arise.

The CCMC staff, including Certification and Renewal Navigators, will be maintaining regular business hours (8:30 a.m.–5:00 p.m. EDT) on a telecommuting basis until further notice.

To ensure you have enough time to complete your CE requirements, we have decided to extend the window for Spring renewals. Therefore, if your CCM is due to expire May 31, 2020, you will now have until June 30, 2020 to complete the CE requirements and apply for renewal.

Given the rapidly changing situation last week, the Commission wants to ensure that all attendees can access quality, equivalent CE opportunities if their attendance was impacted in any way. As a result, we are making opportunities available to all paid Symposium attendees.

With the temporary closure of the Prometric test centers, we have canceled the April CCM exam for the entire month. Those scheduled to take the April exam will now be eligible to take their test between August 1 and September 19 as part of an extended testing window.

For further information, please visit ccmcertification.org/ ■

How Some Hospitals Should Handle Organ Transplants during the COVID-19 Outbreak

One of the big issues right now is how some hospitals should handle organ transplants during the COVID-19 outbreak. Keep in mind, you can allow surgeries, but there are a lot of critical procedures leading up to surgery that could be affected.

The United Network for Organ Sharing (UNOS) is keeping its positions and protocols current during this event. The organization has plans and contingencies in place to "ensure the uninterrupted operation of (their system) and organ center."

One of the key issues that emerges is how to ensure that organ recipient candidates' data scores are not negatively impacted by challenges with clinic visits and laboratory testing.

Among their new guidelines, they maintain that transplant surgeries "should be considered high priority and should not be postponed during the COVID-19 pandemic, if possible." ■

Diabetic Alert Dogs Can't Reliably Detect Blood Sugar Changes From Diabetes

If you research diabetic alert dogs, you'll find a lot of hope for their role in managing type 1 diabetes. And you'll find a fair amount of hype.

Television news stories about the dogs often uncritically accept their abilities, using words like "incredible" and "amazing." In fundraising campaigns, would-be alert dog owners position them as critical solutions to their disease.

NPR reviewed nearly 500 active GoFundMe campaigns that mention "diabetic alert dog." More than a third used phrases like "lifesaver" or "lifesaving."

University of Virginia psychologist Linda Gonder-Frederick tracked the performance of 14 diabetic alert dogs in a 2017 study. Before the study, their owners believed the dogs would prove more accurate than their glucose monitor devices. That didn't happen. ■

US Medical Panel Thinks Twice About Pushing Cognitive Screening for Dementia

Because seniors are at higher risk of cognitive impairment, proponents say screening asymptomatic older adults is an important strategy to identify people who may be developing dementia and to improve their care. But the US Preventive Services Task Force cited insufficient evidence the tests are helpful. The US Preventive Services Task Force said it could neither recommend nor oppose cognitive screening, citing insufficient scientific evidence of the practice's benefits and harms and calling for further studies.

The task force's stance is controversial, given how poorly the health care system serves seniors with memory and thinking problems. Physicians routinely overlook cognitive impairment and dementia in older patients, failing to recognize these conditions at least 50% of the time, according to several studies. ■

Commission for Case Manager Certification Expands Eligibility for Board-Certified Case Manager Examination

As the role of the case manager evolves with changes in health care delivery and reimbursement, the Commission for Case Manager Certification (the Commission) is expanding eligibility and updating knowledge testing for the Certified Case Manager® (CCM®) credential examination to stay current with today's practice.

Effective March 1, 2020, the required amount of work time spent focusing on direct client contact will be reduced from 30% to 20%, allowing more professionals to enhance their knowledge and career through certification. Additionally, there will be changes in the emphasis of test questions in key knowledge domains to align with the roles and functions performed by case managers.

These changes were informed by the Commission's 2019 Role and Function Study, a rigorous assessment of the current knowledge and skills needed for competent, effective case management performance. Conducted every 5 years, the study gathers data about how the field of case management is changing and the knowledge, skills, and activities required in case management practice.

"The study findings affirm that case management is becoming an even more vital part of our health care delivery system as we transition to a value-based and person-centered system of care," said MaryBeth Kurland, the Commission's CEO. "Our decision to expand eligibility for the CCM exam reflects the increased depth and breadth of roles that case managers are playing across a greater variety of workplace settings. As the governing body of the CCM credential, the Commission is committed to ensuring that certification requirements evolve to reflect what's happening in real-world practice."

The 2019 study indicated a greater percentage of social workers—11.2%—make up the case management workforce, a nearly 50% increase from 2014. This rise is consistent with the increased focus on social determinants of health as part of the care management continuum.

Other key findings:

- An increasing number of younger, recently certified professionals while mid-career point professionals remain highly represented. This demonstrates that case management is a profession that is appealing to young professionals and is fulfilling over the long term.
- A strong emphasis on training on-the-job, likely because of the influx of younger entrants into the workforce or those transitioning into case management from other professions such as social work.
- Decreasing emphasis on disease management roles, likely because of the focus on population health and chronic care management as part of the shift to value-based care.
- A consistent emphasis on ethics and quality measurement as core competencies for professional case managers.
- To learn more about the Commission's 2019 Role and Function Study, please visit the summary on its website. ■

Inequalities in Health Care

Is the health care system ready to serve an America that grows increasingly diverse by the year? In an opinion piece for Modern Healthcare, Commonwealth Fund President David Blumenthal, MD, discusses his fear that the nation's health professionals and health care institutions are "woefully ill-equipped."

US health care, Blumenthal writes, has a long way to go to address and overcome the racism and treatment bias that contributes to black women dying from pregnancy-related complications at up to 4 times the rate of white women and from breast and uterine cancers at rates 41% and 98% higher.

"Public policy, demography and the march of technology are making ever more pressing the need for health care providers…to end racism where it originates, in the thoughts and attitudes of a country that has embraced racism, overtly and covertly, for most of its history." ■

Craig H. Neilsen Foundation Announces Funding Opportunity for Psychosocial Research

The Craig H. Neilsen Foundation is pleased to announce its Psychosocial Research (PSR) funding opportunity, opening February 12, 2020. Eligible organizations interested in research to address psychological and social factors that affect health, functioning, and quality of life for people living with SCI are encouraged to apply ■.

Seeking Ways to Combat Loneliness

Medicare Advantage insurers are targeting loneliness among seniors as data show that socially isolated people are 50% more likely to die prematurely. Seniors are at particular risk, as they may face mobility challenges or may fall out of contact with friends and family. A recent study from CVS Health found that 24% of people 65 and older have no one living nearby to support them and 27% don't know where they can go to meet new people. Surprisingly, millennials may have more challenges with loneliness than seniors. It's believed that the challenges millennials face may worsen alcohol abuse and mental illness. ■

Why Home Health Care Is Suddenly Harder to Come by for Medicare Patients

Medicare has changed how it pays for services. In response, agencies across the country are firing therapists, limiting physical, occupational, and speech therapy, and terminating services for some longtime, severely ill patients. ■

Common Drugs May Be Linked to Dementia

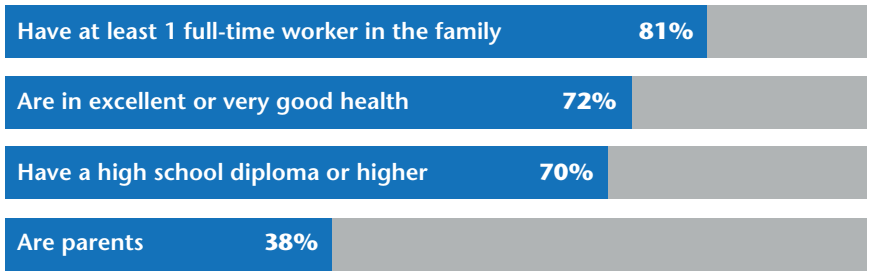
Some disturbing new science says popular drugs may contribute to loss of memory and brain function, according to an article in JAMA. Nearly 60,000 patients who were using anticholinergic antidepressants, antiparkinson drugs, antipsychotic drugs, bladder antimuscarinics, and antiepileptic drugs were part of the study. Study results showed memory loss in the short-term and "significant associations of dementia risk" with long-term use. ■

Do Hospital Alarms Torment Patients?

Tens of thousands of alarms shriek, beep, and buzz every day in every US hospital. All sound urgent, but few require immediate attention or get it. Nearly every machine in a hospital is now outfitted with an alarm—infusion pumps, ventilators, and bedside monitors tracking blood pressure, heart activity, and a drop in oxygen in the blood. Even beds are alarmed to detect movement that might portend a fall. The glut of noise means that the medical staff is less likely to respond.Alarms have ranked as one of the top 10 health technological hazards every year since 2007, according to the research firm ECRI Institute. That could mean staffs were too swamped with alarms to notice a patient in distress or that the alarms were misconfigured. The Joint Commission, which accredits hospitals, warned the nation about the "frequent and persistent" problem of alarm safety in 2013. It now requires hospitals to create formal processes to tackle alarm system safety. But there is no national data on whether progress has been made in reducing the prevalence of false and unnecessary alarms.

The Commission has estimated that of the thousands of alarms going off throughout a hospital every day, an estimated 85% to 99% do not require clinical intervention. Staff, facing widespread "alarm fatigue" can miss critical alerts, leading to patient deaths. Patients may get anxious about fluctuations in heart rate or blood pressure that are perfectly normal, the commission said. What's more, the alarm fatigue creates a "cry wolf" attitude among staff. ■

4 Things to Know About Undocumented Adults Ages 19–36



KFF.org

Applying Behavioral Economics to Hypertension Management

WellCare Health Plans is partnering with digital health company Wellth to launch a new program to help at-risk Medicaid members better manage their hypertension.

The companies plan to start with 200 members in New York with hypertension; they will provide medication reminders through Wellth's app and will offer financial rewards to those who reach certain health goals, such as switching to a low-sodium diet or sustaining medication adherence. The initiative is funded by the National Institutes of Health (NIH) and will run through August, according to the announcement. At the end of the initial pilot, NIH will also review the results, WellCare said. ■

continued from page 13

- Saturday began with an industry-sponsored session titled *Understanding Challenges/Identifying Solutions: Care Transitions,* by Option Care.

Following presentations included:

- *Innovative Advocacy: Remote Work Is Now,* a timely ethics session by Raine Arndt-Couch, JD, LCSW/LCSW-C, CCM
- *Please Let Me Die: A Story of Ethical Conflict,* another ethics session presented by CCMC Commissioner Vivian Campagna, SN, RN-BC, CCM
- *Integrating Teams to Integrate Care: A New Normal,* a presentation by Patrick Gordon, MPA

The entrance into the exhibit hall featured a big thank you to Symposium supporters who share CCMC's goal of nurturing and growing a reliable, well-prepared professional case management workforce.

- *Case Management Practice Analysis: Evolution of the Practice Over the Past Two Decades,* by Hussein Michael Tahan, PhD, RN, FAAN

Closing out the Symposium was Ruben Gonzalez, an Olympic luge racer who competed at age 47! His presentation, *Becoming Unstoppable—Success Secrets of a Four-Time Olympian,* inspired participants to discover tools of perseverance and maintain a belief in self.

A bonus lunchtime educational session featured table "Hot Topics" that featured ethics, geriatrics, technology, and self-care. What better way to discuss these subjects than over a healthy lunch!

In all, Symposium attendees enjoyed many sessions for ethics continuing education credit as well as timely and practical sessions on topics of value to both nurse and social work case managers. CM

LITSCAN FOR CASE MANAGERS

continued from page 36

methods (behavioral tasks, diabetes device downloads, self- and parent-report). We will use an intent-to-treat framework using generalized linear mixed models to test our hypotheses that: 1) the treatment group will demonstrate greater improvements in SR than the control group, and 2) the treatment group will demonstrate better treatment regimen adherence outcomes than the control group.

DISCUSSION: If successful, SR-focused behavioral interventions could improve health outcomes among adolescents with T1D and have transdiagnostic implications across multiple chronic conditions requiring treatment regimen adherence.

Happy 25th Anniversary

continued from page 3

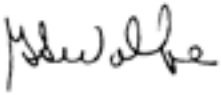
Without your continued interest, we would not exist. We bring you new knowledge bimonthly reflecting best practices of case management practice, and we want to thank you for making *CareManagement* the leading publication in medical case management.

As Charles Dickens wrote, "It was the best of times; it was the worst of times," which may be a description of the future of case management. As health care becomes more complex, the demand for case managers will increase. Our knowledge will be challenged because of this growth. With your help, *CareManagement* will continue to improve case management through education.

One of the challenges we face today is the coronavirus pandemic. There is light at the end of the tunnel—we will pull together and be stronger because of this pandemic. Perhaps our most important role as case managers is to educate patients, family, friends, and neighbors about the pandemic. We are being bombarded with information every day, but we must ensure that we rely on solid medical/scientific sources for information. Be vigilant and stay well.

It has been a wonderful journey.

Happy 25th anniversary!



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ACCM: Improving Case Management Practice through Education

CE II **Projecting the Future of Case Management in the 22nd Century**
continued from page 27

case manager drive outcomes or should the system be accountable for outcomes? Case management is expanding from community-based managed care and hospital care coordination to population health and collaborative care models. The future mandates that case management leaders, certifying/accrediting bodies, and member associations constantly reevaluate the value proposition of case managers as client and/or health system advocates for care management. The value proposition will drive new pursuits to acquire advanced knowledge, skills, and abilities for navigating innovative, nontraditional, and complex environments of care management. **CE II**

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Q: Is your Website secure for dues payment?
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