

CareManagement

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

Vol. 27, No. 2 April/May 2021

INSIDE THIS ISSUE

CONTINUING EDUCATION ARTICLES:

13 Guilt and Shame: Factors in Care Management **CE1**

Thomas L. Blakely, LMSW, PhD

Guilt and shame are factors in emotional distress that clients may hide from their care manager. This article discusses the generation of guilt and shame and ways to manage these feelings.

17 Patient-Centered Care Using Patient Perspective to Address the Social Determinants of Healthcare to Reduce Admissions **CE2**

Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, and Ellen Walker, MSW, LCSW, ACSW

Potentially preventable readmissions have been connected to insufficient or ineffective discharge strategies. Case managers have long made the connection between social determinants of health (SDOH) and increased risk for readmission through anecdotal observation. Failure to create overarching strategies to address the gaps caused by SDOH continues to impact the care continuum's ability to adequately equip the patient for success postdischarge.

22 Defining Values to Improve Culture, Job Satisfaction, and Decision Making

Shanna Huber, BSN, MSN/Ed, RN, CCM, CLCP, CNLCP, CMC

Values are the fundamental beliefs of a person or an organization. This article discusses the process of defining personal core values, creating and defining organizational core values, and incorporating these values in difficult decisions care managers are often faced with within the work environment.

CE Exam **CE**

Members: Take exam [online](#) or print and mail.

Nonmembers:

[Join ACCM to earn CE credits.](#)

SPECIAL SECTIONS:

28 **PharmaFacts for Case Managers**

Approvals, warnings and the latest information on clinical trials—timely drug information case managers can use.

31 **LitScan for Case Managers**

The latest in medical literature and report abstracts for case managers.

DEPARTMENTS:

2 From the Editor-in-Chief

Working with Patients Who Experience Guilt and Shame

5 Legal Update

How to Connect with Patients

6 From the Executive Editor

Spring is Here...And Not a Moment too Soon

7 News from CMSA

Seasons!

8 News from CCMC/CDMS

Raising the Bar on Continuing Education for Case Managers

10 News from MHS (Military Health System)

Case Management for the Seriously Ill and Injured Sailor and Marine

11 Case Manager Insights

COVID-19 Hotline: Connecting Patients to Care

12 News from CARF

Providing Case Management Telehealth—Am I Ready?

39 How to Contact Us

39 FAQs

40 Membership Application

join/renew
ACCM online at
academyCCM.org
or use the application
on page 40



Gary S. Wolfe

Working with Patients Who Experience Guilt and Shame

Guilt and shame are part of life and are experienced by most people. Excessive guilt and shame can affect health, and thus guilt and shame are important issues for the case manager to understand in order to deal with patients more effectively.

Shame and guilt are commonly confused. The difference between shame and guilt is that guilt refers to a behavior and shame refers to an identity. Shame is defined as the painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging. Shame is a protective emotion. It will shut down other emotions and disconnect you from those around you. When our emotions are shut down, it shuts down our body and can even trigger the nervous system to perceive a potential threat. This triggers a fight or flight response. When our sympathetic nervous system is triggered, our bodies are not able to heal. It is all about survival mode, which is not meant for long periods. Survival mode includes invalidating pain and engaging in unhealthy behaviors. Shame can be recognized by “I statements.” For example, “I’m not good enough.” “I’m not trying hard enough.” “I’m lazy.” “I’m dumb.” Shame can be recognized by a physical reaction. Most people feel flush in their face and neck. Some people sweat. Some people tuck their heads, move their shoulders forward, and bend forward slightly at the waist.

Guilt is an emotion and refers to our sense of having done something wrong, either in reality or in our imagination. It relates to real or imagined actions or inactions that have caused real or

imagined harm to others. Guilt is the greatest destroyer of emotional energy. It leaves you feeling immobilized in the present by something that has already occurred.

Guilt and shame often go hand in hand. We might feel guilty about something we have done but ashamed about how this reflects on who we are. However, guilt and shame can also be experienced independently. For example, one may feel guilty about having passed on an infection to someone else without

feeling ashamed. One might feel ashamed about our physical appearance without any sense of guilt. Guilt is

often overt and upfront, whereas shame tends to hide itself and is thus often harder to identify both for the person feeling shame and for the person trying to help. Shame seems to have a closer link to the body through our autonomic nervous system (eg, blushing).

It is useful to establish the relative contribution of guilt and shame to the patient’s distress, bearing in mind that they may not be able to describe shame (patients often use the term “embarrassed” when they are actually referring to something much more uncomfortable than embarrassment). When exploring guilt, it is important to determine whether the guilt is proportionate to what the patient has done. If it is disproportionate, one can begin to unravel the various factors in the patient’s life that may be contributing to the feelings of guilt. This may take some time but can lead to a more realistic appraisal of how responsible they are for their feelings of guilt.

continues on page 4

Editor-in-Chief/Executive Vice President

Gary S. Wolfe, RN, CCM

Editorial Board

Barbara Aubry, RN, CPC,
CHCQM, FAIHCQ

Jennifer E. Voorlas, MSG, CMC

Adele Webb, RN, PhD, AACRN,
CPNAP, FAAN

Executive Editor

Catherine M. Mullahy,
RN, BS, CCRN, CCM

Contributing Editor

Elizabeth Hogue, Esq.

Copy Editor

Esther Tazartes, MS

Art Director and Webmaster

Laura D. Campbell

Circulation Manager

Robin Lane Ventura

Member Services Coordinator

Kathy Lynch

Senior VP Finance & Administration

Jacqueline Abel

Publisher, President

Howard Mason, RPh, MS

Vol. 27, No. 2, April/May 2021. *CareManagement* (ISSN #1531-037X) is published electronically six times a year, February, April, June, August, October, and December, and its contents are copyrighted by Academy of Certified Case Managers, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990; Tel: 203-454-1333; Fax: 203-547-7273.

Subscription rates: \$120 per year for ACCM members; \$150 for institutions.

Opinions expressed in articles are those of the authors and do not necessarily reflect the opinions of the editors or the publisher or the Academy of Certified Case Managers. One or two copies of articles for personal or internal use may be made at no charge. For copying beyond that number, contact Copyright Clearance Center, Inc. 222 Rosewood Dr., Danvers, MA 01923, Tel: 978-750-8400.

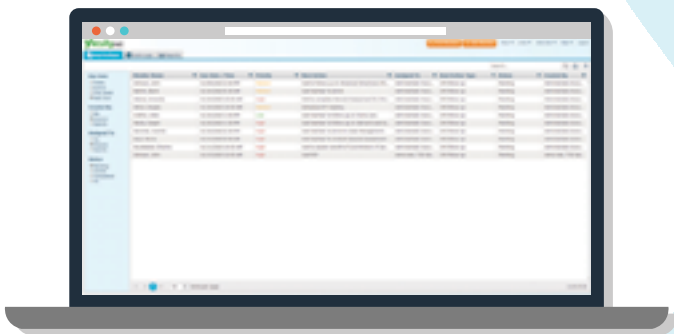
CareManagement is indexed in the CINAHL® Database and Cumulative Index to Nursing & Allied Health Literature™ Print Index and in RNdex.™

© Academy of Certified Case Managers, Inc. 2021



Population Health Designed by Clinicians

Our SaaS offering, ACUITYnxt, offers an end user experience that is intuitive and supports a whole-person approach to managing care. ACUITYnxt offers workflows that are designed to meet both regulatory and accreditation industry standards with little need for customization.



ACUITYnxt Supports:

- Stratification and Automation
- Case Management
- Disease Management
- Behavioral Health
- Health Risk Assessments
- Authorizations
- Billing and Invoicing

Built with security in mind, ACUITYnxt is protected by industry-verified security, privacy controls, data encryption, and compliance.

ACUITYnxt is Certified: HIPAA, SOC2 and HITRUST. The platform enables organizations to seamlessly integrate data such as Members, Eligibility and Providers or extend ACUITYnxt by leveraging our APIs.

Secure
Healthcare
Cloud



Elizabeth E. Hogue, Esq. New Contributing Editor

I am pleased to announce that Elizabeth E. Hogue, Esq., has been appointed a Contributing Editor for *CareManagement*. Hogue is an attorney in private practice with extensive experience in healthcare. She did her undergraduate work at Emory University and received a Doctor of Jurisprudence with honors from the University of Maryland Frances King Carey School of Law with a concentration in health law, and she has considerable clinical experience, coursework, and employment experience in this area. Following her admission to the Bar, she developed an active practice in health law. She represents clients all over the country, including professional associations, physicians, managed care providers, and institutional health care providers. She has represented several individual providers and case managers concerning health-related issues. Hogue has been active in professional case management, educating and advising case managers about the legal issues, pitfalls, and challenges case managers address in their daily practice of case management. She is a recognized national speaker and author on legal issues in healthcare. She has written extensively on health-related topics, and her articles are regularly included in trade association publications and other journals. Her books include *Nursing Case Law Reporter*, *Informed Consent*, *Legal Liability*, *Medicare/Medicaid Fraud and Abuse*, *Contracting with Managed Care Providers*, *Ethics Manual*, *Termination of Services to Patients: Use of Policies and Procedures to Avoid Liability for Abandonment*, *Case Management: Legal Issues*, *How to Develop a Fraud and Abuse Compliance Plan*, *How to Form Alliances Without Violating the Law*, *Wound Care: Legal Issues*, and *How Marketers Can Get Referrals without Breaking the Law*. Ms. Hogue is a member of the American Health Lawyers Association.

CareManagement has published Hogue's contributions in our legal column for many years, and we will continue to publish them. It is an honor to welcome Elizabeth E. Hogue, Esq., as a Contributing Editor.

Working with Patients Who Experience Guilt and Shame

continued from page 2

It is also important for the case manager to be sensitive to cultural differences in the experience of guilt and shame. The cultural differences may relate to macrocultures (eg, membership in an individualist or collectivist culture) or to microcultures (eg, membership in a street gang).

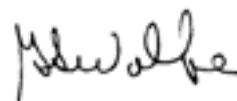
The two key therapeutic concepts in working with guilt and shame are acceptance and forgiveness. An accepting attitude towards the patient promotes the patient's self-acceptance. Acceptance involves a way of being with a patient, warts and all, without needing to make a moral judgement about him or her. It is a way of being that does not need to jump to conclusions or act precipitously. Overzealous attempts to "make the patient change" may paradoxically leave them feeling not accepted. Acceptance is communicated by nonverbal (eg, posture and facial expression) and verbal cues.

Forgiveness is addressed in most mainstream religious faiths, although it is often particularly associated with Christianity. In working with guilt, especially guilt that is proportionate to what the individual has done, we are primarily concerned with self-forgiveness. Like forgiveness of others, this needs to be seen as a process.

Here are some practical steps in dealing with guilt and shame:

- Look out for the word "should"
- Be kind
- Let it go
- Accept limitations
- Focus on the positive
- Be objective
- Stop magnifying
- Recognize that feelings of guilt and shame are counterproductive
- Use mindfulness to disengage with the story of guilt and shame

For additional information on guilt and shame, I recommend the article titled "Guilt and Shame: Factors in Care Management" by Thomas I. Blakely, LMSW, PhD, in this issue.



Gary S. Wolfe, RN, CCM, Editor-in-Chief
gwolfe@academyccm.org

**ACCM: Improving Case Management
Practice through Education**

How to Connect with Patients

Elizabeth Hogue, Esq.

A Special Communication, entitled “Practices to Foster Physician Presence and Connection with Patients in the Clinical Encounter,” by Donna M. Zulman, MD, MS, et al.; recently appeared in the Journal of the American Medical Association (JAMA) [2020;323(1):70–81. doi:10.1001/jama.2019.19003]. Although this article is directed to physicians, the activities described in the article also clearly apply to all practitioners. The article asks an extremely important question: What are the most promising practices to foster presence and connection with patients?

The study upon which the article is based identified the following five practices that will likely enhance presence and meaningful connection with patients during visits:

- Prepare with intention
- Listen intently and completely
- Agree on what matters most
- Connect with the patient’s story
- Explore emotional cues

Prepare with Intention

Intentional preparation includes two key activities: (1) personalized preparation for the patient and (2) taking a moment to pause and focus.

Personalized preparation involves becoming familiar with the person about to be seen to facilitate a more immediate connection with the patient. Reviewing patients’ charts prior to visits with them is an example of personalized preparation.

The second component of preparation requires taking a moment before or at the beginning of visits during which practitioners clear their minds of distractions and set the intention for encounters with patients. Practitioners sometimes engage in this activity while

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.

The following five practices will likely enhance presence and meaningful connection with patients during visits:

- Prepare with intention
- Listen intently and completely
- Agree on what matters most
- Connect with the patient’s story
- Explore emotional cues

washing or sanitizing their hands prior to meeting with patients.

Listen Intently and Completely

This practice also includes two components: (1) listening with one’s whole body using open and receptive body language and (2) avoiding interruptions.

The first component includes sitting down, leaning in, maintaining an open body position and orienting one’s body toward patients. The goal is to convey openness and respect, as opposed to dominance.

The second key component of this practice is to avoid interrupting patients, especially during patients’ opening descriptions of active health issues. Research shows that practitioners routinely interrupt their patients within eleven seconds! Practitioners should use silence and infrequent,

timely and considered questions when patients are telling their stories.

Agree on What Matters Most

This activity focuses on discovering what is most important to patients and developing shared priorities. A key initial question is: “What is your main question or concern for today?” Toward the end of the visit, it is important to ask: “Is there something else you want to address today?”

Connect with Patients’ Stories

This activity includes consideration of personal circumstances that influence patients’ health and acknowledgement of patients’ efforts, including celebration of successes.

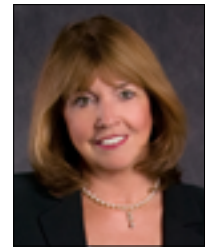
With regard to the first component, practitioners should ask patients about their sociocultural background and life circumstances. Practitioners should “look at the world through the patient’s eyes and walk through the world in the patient’s shoes.”

Examples of the second component include positive language such as statements of approval, empathy, and reassurance as well as offering praise for patients’ efforts and acknowledgment of small successes.

Explore Emotional Cues

Practitioners should take note of

[continues on page 36](#)



Catherine M. Mullahy

Spring is Here...And Not a Moment too Soon

Spring has finally arrived and with it some very encouraging news. The success of the vaccine rollout continues, and schools and businesses are reopening although there are some bumps along the way. Thankfully, with the determined efforts of so many, our country is recovering.

We at *CareManagement* have continued to inform and educate our readers about issues that are important to them as well as to their patients. It's frequently challenging to anticipate how to engage our readers, especially when we understand how many of you are trying to balance competing professional and personal priorities. There is an increasing emphasis on value-based health care and the metrics that underscore and communicate the triple aim of healthcare: improving health of populations, reducing per-capita costs, and improving patient satisfaction through quality, safe care. Case managers are striving to strike a balance in achieving the triple aim.

We try to be mindful of the triple aim when we create each issue. Note the reference to create. *CareManagement* has posted on various social media sites and directly with our various partners—CCMC, CMSA, CARF, and now Veterans' Affairs (VA) and Military Health System (MHS). The first column from MHS is in this issue! We would like your feedback regarding content that you would like us to publish. Your participation in this process is incredibly valuable, and we really welcome any/all suggestions and requests. Many of you obtain your CEs from the various

articles in the journal (there are 3 CE articles per issue), and we publish articles that are preapproved for ethics twice per year. I strongly recommend that you read the ethics-focused article in this issue by Shanna Huber, BSN, MSN/Ed, RN, CCM, CLCP, CNLCP, CMC. Shanna challenges us to define the core value for the organizations we work for. Per Shanna, if you don't know the organizational values, "it's time to create them!"

Patient Safety Week was held March 14–20. It is interesting that we designated only 1 week to raise the awareness of patient safety when we recognize that this should be our focus every day. As case managers and advocates, we should be mindful of how we can promote a culture of safety for our patients across the care continuum, which is getting more challenging all the time. With so many of our patients receiving their care in an increasing number of settings, it's overwhelming to ensure that the standards of quality and safety are the same for each of them. Since case managers are typically charged with transitioning and coordinating care within a myriad of inpatient and community-based settings, the responsibilities become not only challenging but legally precarious.

Some statistics from a publication that I read are alarming. While deaths from COVID-19 continue to increase, but thankfully at a reduced number, mortality resulting from medical errors in the United States is estimated at 251,000 deaths per year or 688 preventable deaths per day.

There are other studies that cite the number of preventable deaths as high as 400,000 per year. Which reference we use is not as important as the fact that these are preventable occurrences. As innovators, case managers can take the lead in addressing these problems and perhaps consider pursuing a Certified Professional in Patient Safety (CPPS) credential (<http://www.ih.org/education/cpps-certified-professional-in-patient-safety/Pages/default.aspx>). Having professionally certified case managers (CCMs) with additional expertise in Quality and Safety Education (CPPS) would certainly expand the role of case managers in a within an organization. While individual case managers can make a difference, those in leadership positions can have an even greater impact as we address two monumental crises in healthcare: the COVID-19 pandemic and preventable deaths from medical errors, which should certainly be considered a crisis.

The good news is we have the tools, resources, continued resilience, determination, and optimism to make a difference...one patient at a time!

Catherine M. Mullahy

Catherine M. Mullahy, RN, BS, CCRN, CCM, Executive Editor
cmullahy@academycm.org

**We *can* make a difference...
one patient at a time.**

Seasons!

Melanie A. Prince, MSN, BSN, NE-BC, CCM, FAAN

Several months ago, I wrote about the difference between change and transition according to William Bridges' Transition Model (Bridges, 1981). He described change as an external process that happens to a person or organization and involves a shorter time frame than transition. Conversely, transition is an internal experience that takes a longer time and involves several phases. As the spring season gets underway, I am excited about the rejuvenation, revitalization, and newness of everything as nature transitions from its winter restoration. As a daughter of the South where, March to May is a flurry of preparation for cultivating gardens and farmland, I view transition from the prism of seasonal crop rotations for productive harvests.

Farmers and growers understand that the soil transitions from year to year as crops consume nutrients and the cultivation environment responds to external events. The remedy is to rotate crops by planting something

Melanie A. Prince, MSN, BSN, NE-BC, CCM, FAAN, is president of the Case Management Society of America.

Recently retired as an Air Force colonel, Melanie

has diverse experience in population health; case, disease and utilization management; public policy; trauma/violence prevention and organizational leadership. Melanie is a certified professional case manager and nurse executive and has master's degrees in nursing case management and military strategic studies.



different to produce a better yield. This does not mean the previous crops were bad, but the change and rotation ensure bigger, better yields for the future. Merriam-Webster defines the purpose of growing different crops on the same land as a way to preserve the productive capacity of the soil. This is

CMSA is providing webinars, courses, and roundtables on topics that affect case managers in today's environment. These topics range from leadership, mentorship, and clinical practice to COVID care management, vaccine hesitancy, and health disparities.

a perfect metaphor for CMSA's year of transition and the coming seasons of 2021 (<https://www.merriam-webster.com/dictionary/crop%20rotation>).

CMSA has successfully responded to changes within the external environment, from healthcare industry adjustments to the public health pandemic crisis, to the ensuing economic impact on the case management profession. Danish philosopher Søren Kierkegaard also used the metaphor of crop rotations to advocate for changing the "method of cultivation and the kinds of crops" rather than "changing the soil" in the context of personal growth. He advocated for "broadening one's horizons and divergently apply new skills to old ideas or new ideas to old skills" (Kierkegaard, 1852).

Kierkegaard suggested that "the nature of this pivot need not be a radical change of land but can remain rooted in the soil it grew from." This metaphor is also apt for organizations and especially for CMSA as we launch new and exciting programs. We will support and elevate the case management profession in many different ways and plant a variety of "strategic seeds" that will produce a harvest of curricula, tools, and products for an ever-changing healthcare landscape.

CMSA is excited about future yields from the ongoing efforts of its leaders, members, sponsors, and supporters. A few examples of CMSA's priorities are as follows:

- Collaborative policy making with organizations that have a mutual mission
- Partnerships with companies that influence the case management profession
- Reconnecting with legacy leaders and professional groups that align with CMSA's goals
- Professional development for all disciplines that elevates case management practice
- Drive a "Lift all boats" strategy that ensures chapter progress and achievements
- Embrace technology that supports the patient/client/family experience
- Leverage professional case management in diverse areas of healthcare that promotes new opportunities and the ability to

[continues on page 38](#)

Raising the Bar on Continuing Education for Case Managers

MaryBeth Kurland, CAE, and Vivian Campagna, MSN, RN-BC, CCM

Over the past year, the pandemic has disrupted not only how and where work gets done—with many professional case managers working remotely—but also how learning occurs. Instructors, trainers, and learners, alike, are to be commended for their agility and adaptability as training that used to occur in person is now conducted virtually (see “[Making the Most of Virtual Training](#)”). However, as colleagues are physically separated, informal peer-to-peer interactions to ask questions and exchange information no longer occur with the same ease and spontaneity.

The learning that happens in the moment is hard to replicate online or in a phone conversation. As a result, case managers have lost many informal opportunities to engage with each other to discuss cases, problems, solutions, and resources. In light of this reality, continuing education has become even more important. Now, the bar needs to be raised to deliver unique and cutting-edge content based on the latest research, evidence-based practices, and relevant challenges facing professional case managers across the health and human services spectrum.

For board-certified case managers, such as those who hold the Certified Case Manager (CCM) credential, earning CEs for certification renewal is an important and ongoing objective. However, professional development should go beyond CEs.

Lifelong learning is the pursuit of knowledge, resources, and tools to elevate one’s competency and increase relevancy. To meet this standard, the quality of continuing education content will become even more important as a differentiator. The focus must be on value-added education, not merely “cookie cutter” content that is widely available and does not appreciably contribute to a case manager’s understanding and development.

Ongoing Learning at the Core of Case Management

Continuing education is vital for keeping pace with the ongoing evolution of case management practice. The profession has evolved over the years, placing a greater emphasis on measuring and analyzing outcomes—both for the organization and the client. The most recent CCM [role and function study](#) conducted by the Commission for Case Manager Certification highlighted the significance of the role played by professional case managers today in health and human services, particularly in care coordination and ensuring the delivery of competent case management services.

The foundation is advocacy—understanding the individual’s goals and providing access to the right care and resources at the right time in support of those goals. Advocacy remains the cornerstone of case management

practice and is also at the center of the professional disciplines that make up case management, such as nursing, social work, rehabilitation counseling, mental health counseling, and more. As a fundamental principle of practice, advocacy is also shared with aligned fields, such as disability management, which addresses the health and wellness of people in the workplace and seeks to mitigate the impact of disability on employees and employers.

A [recent survey](#) of CCMs by the Commission identified other aspects of

MaryBeth Kurland, CAE, is CEO of the Commission for Case Manager

Certification, the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists. The Commission is a nonprofit, volunteer organization that oversees the process of case manager certification with its CCM[®] credential and the process of disability management specialist certification with its CDMS[®] credential.



Vivian Campagna, MSN, RN-BC, CCM, is the chief industry relations officer for the Commission. 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.

their jobs that case managers consider to be most vital. The top responses were:

- ensuring appropriate care
- educating and empowering clients
- coordinating care
- helping clients identify issues and set goals
- helping clients transition from one care setting to the next

Each aspect of the case management role is an extension of advocacy. Although advocacy stems from the very roots of case management, it continues to evolve. Learning about advocacy—how it is defined, delivered, and experienced across health and human services—never ends.

Continuing Education—a Hybrid Experience

The need for quality continuing education and professional

Continuing education is vital for keeping pace with the ongoing evolution of case management practice. The profession has evolved over the years, placing a greater emphasis on measuring and analyzing outcomes—both for the organization and the client.

development brings us back to where this discussion started: how such learning will occur. Virtual training that became a necessity during the pandemic will likely be here to stay. An example is CCMC's [2021 New World Symposium](#), which has been reimaged as a fully virtual event to take place October 12–14, 2021,

in conjunction with National Case Management Week. As participants in previous in-person symposiums experienced, the 3-day virtual event will offer continuing education and professional development across a spectrum of topics and issues in case management today.

In planning a fully virtual event, the Commission will provide live streaming of presentations and workshops, giving participants the ability to ask questions and engage in discussions virtually.

At the same time, it must be acknowledged that not every participant will be online for 3 full days; therefore, sessions will be recorded and made available for viewing as participants choose. In addition to Symposium, apps and other digital tools are available to enhance the learning experience and in some cases the attainment

[continues on page 36](#)



The Value of Prioritization in a Busy World: Indicia for Effective Focus

Watch the Webinar

Learn about MCG's latest solution that leverages machine learning to **prioritize cases**, support workflow **transparency and efficiency**, as well as identify cases that would most likely benefit from early review to **capture potential conversions** and **avoid unnecessary denials**.



Case Management for the Seriously Ill and Injured Sailor and Marine

Joan McLeod, BSN, MGA, CCM, Commander Cambrai Hardy, USN, NC, BSN, BS, MSHCA, and Lorri Ward, MSN, RN

The United States military healthcare system (MHS) is a one of the largest healthcare delivery systems in the country. It is unique and complex in that it delivers healthcare to approximately 1.3 million active duty service members and another 8.3 million other eligible beneficiaries, while caring for those injured in the battlefield. Service members are given emergency care in battle and medically evacuated by air transport to medical hospitals sometimes hours away. The system also has to meet the mission of the military by ensuring that service members are medically fit and ready to meet their challenging assignments, which can be in remote austere locations, on close quartered ships, submarines, and airplanes. At all the military treatment facilities (MTF), which consists of hospitals and clinics that provide care to MHS beneficiaries, the active

duty service members are the priority for access to care. Through the MHS TRICARE program some beneficiaries receive care outside of the military hospitals and clinics through “management care support contractors” with civilian healthcare programs. Managing TRICARE beneficiaries requires some basic knowledge of the TRICARE program.

Familiarization with key components of the MHS case management system specific to the care of the Navy and

managers often known as Recovery Care Coordinators (RCC), providing support to service members who have serious injuries or illnesses that make it unlikely to return to active duty or service members with severe or catastrophic injuries or illnesses, who most likely will be medically retired from the military.

The focus of case management for these cases is on supporting a recovery service member’s rehabilitation and reintegration back to active duty or veteran status. For those whose medical condition is not conducive to continuing service, the focus is on successful transitions of care without gaps in care, coverage of all military benefits, and related services including engagement in health care rendered at nonmilitary, civilian hospitals, or Veterans Affairs facilities. The RCC provide nonmedical support such as assistance with resolving financial, administrative, personnel, and logistical military problems for the service member and families. They assist with finding resources to maintain or improve the service member’s quality of life while preparing them for life outside of the military. They collaborate with Department of Defense and civilian organizations that provide programs for posttraumatic stress disorder/substance use disorder, traumatic brain injury rehabilitation and reintegration, adaptive recreation, and adaptive athletics programs that enhance recovering service members.

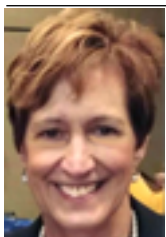
An individualized comprehensive

[continues on page 36](#)

Each of the Services—Army, Air Force, Navy, Marine Corps, and Coast Guard—have Wounded Warrior medical and nonmedical case management programs specifically designed to address the needs of the most severely wounded, ill, and injured service members.

Marine Corps active duty population with serious or severe illnesses and injuries is the focus of this article with some basics of the TRICARE program. Each of the Services—Army, Air Force, Navy, Marine Corps, and Coast Guard—have Wounded Warrior medical and non-medical case management programs specifically designed to address the needs of the most severely wounded, ill, and injured service members.

Medical case managers work with Service-specific nonmedical case



Joan McLeod, BSN, MGA, CCM, is the Medical Management and Referral Management Program Manager for the Navy Bureau of Medicine and Surgery. **Commander Cambrai Hardy, USN, NC,**

BSN, BS, MSHCA, is the Commander, Navy Installation Command, for the Navy Wounded Warrior Program, **Lorri Ward, MSN, RN,** is the Regimental Nurse Case Management and Benefits Advisor for the Headquarters Marine Corps Wounded Warrior Regiment.

COVID-19 Hotline: Connecting Patients to Care

Kellea Hendrian, BSN, RN, CCM

A real-life application of a case manager answering the call of those in need.

As an emergency response to the COVID-19 pandemic in March 2020, a local hotline staffed by clinical registered nurses evolved. The purpose of the Blessing Health System COVID-19 Hotline is to triage care for ill individuals, increase access to testing, reduce unnecessary emergency department visits, provide accurate information to the public, reduce misinformation, and reduce transmission of virus.

Clinical nurses who staff the Blessing Health System COVID-19 Hotline practice independently at the highest scope of practice and use critical thinking skills and clinical judgment. This group of registered nurses devote countless hours to ensure that community members are provided with accurate information and education. Additionally, the team has mastered frequent process changes with a clinical algorithm, testing recommendations, travel policies, and (currently) vaccination registration.

From urgent phone calls seeking emergency treatment to frightened

Kellea Hendrian, BSN, RN, CCM, has over 10 years of healthcare experience as a licensed registered nurse in the state of Illinois and is certified by the Commission for Case Manager Certification. Kellea is a facilitator for Shared Governance, lead of a multidisciplinary team to improve patient outcomes, lead magnet writer, and Daisy Award coordinator. Kellea will graduate in May 2021 with a master of science degree in nursing administration and leadership.

parents seeking instructions to care for their children to employers calling for testing guidelines to instruct their workforce—no call has gone unanswered. The nurses have spent hours calming fears and triaging the ill while

her child effectively in a home with multiple children. As I explained the quarantine guidelines to the mother, I could tell that her fears and anxiety decreased, but it was also evident that the family needed additional help.

Clinical nurses who staff the Blessing Health System COVID-19 Hotline practice independently at the highest scope of practice and use critical thinking skills and clinical judgment. This group of registered nurses devote countless hours to ensure that community members are provided with accurate information and education.

executing the local COVID-19 response behind the scenes.

Throughout the pandemic and the ever-changing landscape of healthcare, case managers continue to help patients navigate the healthcare system. During surges of cases and flattening of lines, case managers are sought after for new ways of connecting and assisting patients.

As an example, I would like to share with my fellow case managers and readers of *CareManagement* the following application of a case manager's skill set. This late-night phone call reminds me just how valuable each of you are in the healthcare landscape.

A worried and distraught mother needed answers to her questions late on a recent Friday night. What she received were answers to her prayers. The woman's 18-month-old son had tested positive for COVID-19 and she needed to know how to quarantine

The mother shared with me that she and her significant other were no longer working because of the pandemic, which made her worried that she would not be able to take care of her children. Before the call ended, I made sure that the family had necessities for the weekend, but I simply couldn't stop thinking about the family's plight. By Monday morning, I had a plan. I contacted the Blessing Health System Outpatient Care Coordination department to discuss the family's situation and to determine what assistance, if any, was available to them.

The Care Coordination team consists of nurses, social workers, caseworkers, professional counselors, and support staff who work with individuals and families in the region to ensure access to the right healthcare at the right time and to connect people with other services they may need to

[*continues on page 38*](#)



Providing Case Management Telehealth— Am I Ready?

Christine M. MacDonell, FACRM

As COVID 19 began in early 2020, states moved at different rates to begin shutting down health and human services. Many of the individuals who were receiving case management services and case managers had limited mechanisms for face-to-face meetings. Access to nonemergency care was restricted. Being able to serve individuals became part of strategic planning, financial planning, and workforce development. Case managers and all health care providers had to explore new methods to provide services. Many turned to using telehealth to provide their services. Behavioral health is one health and human service arena that has used telehealth for many years, and behavioral health care providers are aware of the challenges of providing quality telehealth services.

Some the challenges that need to be met in telehealth are:

- Case managers may need training on how to set up, use, maintain, and



Christine M. MacDonell, FACRM, is the Managing Director of Medical Rehabilitation and International Aging Services/Medical Rehabilitation in

Tucson, Arizona. She is part of the medical rehabilitation team responsible for the training of CARF surveyors and for the development and revision of CARF standards.

Based on the individualized plan for the person served, the use of information and communication technology allows providers to see, hear, and/or interact with persons served, families/support system members, and other providers in remote settings.

- troubleshoot the technology used.
- Persons served in case management may need equipment (eg, laptops, tablets, wireless access). Some equipment may be loaned to mitigate access barriers. This requires the financial capability to provide and/or loan this equipment.
- Separate language channels may be needed for persons who require interpreters
- A box of tools and equipment may be needed if arranging physical and/or occupational therapy so that the persons served can participate in the therapy session.
- Case managers need to learn how to broadcast sessions over HIPAA-compliant telehealth services.
- Case managers need to be knowledgeable about a variety of funding sources that allow telehealth services.
- Case managers need to be aware of whether programs/services they are arranging for persons served use telehealth in a responsible and

knowledgeable manner.

- Safety protocols must be established for both the persons served and case managers.

CARF International, as an accreditor, has many organizations providing telehealth services. In the Technology standards, CARF describes information and communication technology (ICT) in the following manner:

Based on the individualized plan for the person served, the use of ICT allows providers to see, hear, and/or interact with persons served, families/support system members, and other providers in remote settings. The use of technology for strictly informational purposes such as having a website that provides information about the programs/services available is not considered providing services via the use of ICT.

The provision of services via ICT may:

- Include services such as assessment, monitoring, prevention, intervention, follow-up, supervision, education, consultation, and counseling.
- Involve a variety of professionals such as case managers, service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, rehabilitation engineers, assistive technologists, and teachers.

[continues on page 35](#)

Guilt and Shame: Factors in Care Management

Thomas L. Blakely, LMSW, PhD

The purpose of this article is to highlight guilt and shame as factors in emotional distress that clients may hide from their care manager. The generation of guilt and shame and ways to manage these feelings are discussed.

Guilt and shame often are the products of the behavior of dysfunctional families (Martin, 2018). Parents who invoke guilt and shame behaviors toward their children probably experienced the same treatment from their parents. Inappropriate discipline of children such as criticism, verbal abuse, and name calling have a temporary effect on correcting wrongful behavior but damage children's self-image. Criticism and disapproval create shame. Children feel they must be bad or their parents would love them. If children are not heard, emotional needs are not met. They believe they are not important. It creates a feeling of powerlessness and can make children fearful of taking a risk or making a mistake. They grow up feeling unimportant and may feel dismissed and diminished. They fear being humiliated and being exposed again (Grille & Macgregor, 2019).

Guilt

Guilt is an emotion or feeling, whether accurate or not, of having violated one's standard of behavior or a religious and moral standard such as found in one or more of the Ten Commandments. Guilt is common in mental distress. It usually is expressive of a state of conflict about what was done that shouldn't have been done or what was not done that should have been (Payne et al, 2008; Koenig & Larson, 2020). Remorse often follows guilt. Remorse may lead to self-resentment, an attempt to repair damage, or self-punishment (Sword & Zimbardo, 2018).

Types of guilt are: 1) guilt for something done that was wrong; 2) guilt for something you wanted to do but didn't do; 3) guilt for something you think you did; 4) guilt over feeling you haven't done enough for somebody; and 5) guilt over feeling more successful than others.

Care managers who have clients that have feelings of guilt should be aware of the severity of their clients' depression. Depression may lead to self-harm (McDonald, O'Brian &

Jackson, 2007) requiring psychiatric intervention.

Shame

"Shame is a powerful emotion that can cause people to feel defective, unacceptable, even damaged beyond repair" (Salters-Pedneault, 2018). Self-esteem is learned through interaction with these figures, especially the primary attachment figure. Lack of self-esteem may generate a feeling of shame. Lack of sufficient attachment results in forming an insecure attachment style of an ambivalent, avoidant, or disorganized type (McLeod, 2018). Behaviors of each of these insecure styles are dysfunctional.

Shame is not a diagnosis. Shame is a negative feeling about the self that usually is the result of criticism or other negative behaviors that create a feeling of being inadequate, inferior, or worthless. The most frequent diagnosis associated with shame is depression. Treatment focuses on reviewing the history of shaming behaviors to rethink and relearn erroneous assumptions made about the self that are linked to shaming incidents. A change to positive behavior and thinking may result by increasing self-esteem that can help clients manage feelings of guilt or shame. Clients may hide these feelings so that a care manager's thoughtful patient inquiry is necessary. Clients' feelings of guilt and shame may affect the relationship with the care management provider.

Managing Guilt

Learning to manage guilt is a way to find relief from the emotional distress it causes. For example, clients raised in an environment in which rigid and strict rules were applied in a punitive manner may have developed feelings of guilt.

Thomas J. Blakely, LMSW, PhD, is a clinical social worker and LMSW licensed by the State of Michigan. He is a Professor Emeritus at Western Michigan University in Kalamazoo, and he was the director of an extended degree program in Grand Rapids, Michigan. He earned a BA degree in sociology at the University of Notre Dame and an MSW and PhD (Edu) at the University of Michigan. He is the author of over 70 published articles on social work theory and practice and mental health issues.

Guilt is an emotion or feeling, whether accurate or not, of having violated one's standard of behavior or a religious and moral standard such as found in one or more of the Ten Commandments.

Cognitive therapy (Beck, 1976) may be effective in managing these feelings. Clients need to think about the faulty development of their conscience through overly strict social training. Retraining feelings through correct thinking can help clients realize the unreality of behavior associated with conforming to rigidity (Beck, 1976).

A religious practice may offer relief from guilt for some individuals. Confession is an example in the Catholic tradition. Care managers can ask clients about religious beliefs and practices. This provides an opportunity to explore how these beliefs and practices may be used to relieve guilt. If feelings of guilt resulted from an act that was harmful or hurtful to another person, asking and obtaining forgiveness may be helpful. One may be able to do something for the individual that was harmed that could compensate for hurtful behavior.

Managing Shame

Helping a client to manage shame requires a restoration of self-esteem (Elison, Garofalo & Velotti, 2014). Being rejected by attachment figures creates a feeling of separation from others, a sense of shame, and a loss of self-esteem (Director, 2017). These feelings lead to dysfunctional behaviors that others don't understand so they avoid the shamed person. This reinforces the shamed individual's self-negating feelings.

Clients need to rethink and relearn perceptions of a negative self that arose from being shamed by the indifference, neglect, or rejection on the part of attachment figures (Ellis & Ellis, 2011). This may be accomplished through recalling shaming experiences during childhood and adolescence. Clients may be helped by recognizing that others may have been expressing their own feelings without seeing the effect on the listener.

The release of feelings of vulnerability, fear, and humiliation is a care management goal. Thinking about the incidents in which shaming occurred may produce a different perspective. If the details of these incidents are recalled it may become apparent that shaming is due to someone else's behavior. The question becomes, what started the shaming? Who is responsible for shaming? What was said or done that was shaming? Is what was said or done realistic or is it the distorted angry projection of the shaming person? Answers to these questions may shed light on the other person's bad behavior. When that is realized, ask clients the following

questions: "How realistic is your feeling of shame?" If clients' histories do not conform to the shaming experience, they can be helped to realize the unreality of a shameful response.

Understanding how shame affects a person helps release it. Overcoming the belief that one is a bad person takes time but it can be done. Some individuals can accomplish this by themselves, but consulting a mental health professional who understands the process of shame release may be necessary. When shame release works and one learns assertiveness in expressing a positive self, self-esteem improves.

Self-Esteem as a Factor in Guilt and Shame

It is every individual's uniqueness that gives worth and esteem. Therefore, it is important to examine one's strengths and potential for accomplishment as indications of self-esteem (Rapp, Saleebey & Sullivan, 2005). Formica (2008) wrote about "instructions" received from others that affect self-esteem. He provided an example of the "instruction" that being chosen last for a team sport expresses the view of others you are not very athletic. This is a shaming experience that diminishes self-esteem. He suggested that shame results from the alacrity of accepting others' opinions. Managing shame is ceasing to live by the reflections of others and instead reflecting objectively on ourselves and our strengths.

Humans have a combination of unique characteristics. What we learn as we develop, primarily from attachment figures, determines self-esteem. Self-esteem is established when these relationships are positive and internalized. If these relationships are characterized by indifference, neglect, or rejection, it is likely that a negative sense of self will be internalized. This may generate assumptions about reality that are erroneous and decrease self-esteem (Bowlby, 1988).

Elison, Lennon, & Pulos (2006) wrote about Nathanson's "Compass of Shame Scale," which may be helpful to care managers who are helping clients with feelings of shame. The Scale assesses styles of coping with shame: Attack Self, Withdrawal, Attack Other, and Avoidance. Yelsma, Brown, & Elison (2002) wrote about the association of these coping styles with self-esteem. The use of the Compass Scale as an intervention for the treatment of shame disorders is part of the Restorative Process (Wachtel, 2019). The intervention begins with the client and the care manager discussing the four coping mechanisms in the Scale. This discussion leads to clarification and improved

Shame is a negative feeling about the self that usually is the result of criticism or other negative behaviors that create a feeling of being inadequate, inferior, or worthless.

understanding of shaming experiences and what needs to be restored to resolve a shaming disorder. The Restorative Process begins with clients' expressing their feelings about the shaming circumstances in their lives and how they are reacting. This can release the intensity of negative feelings.

Another restorative process is the "restorative conference" that brings together those who have caused harm through shaming with those they have directly or indirectly harmed. Since shaming frequently occurs in families, a restorative conference brings families together to discuss shaming experiences (VanWormer, 2003). With the help of a skilled care manager, feelings of the shamed family member can be expressed and validated. This could lead to apologies for errant behavior or at least an explanation that may contribute to an improved family atmosphere and relationships. Nathanson wrote that in a restorative conference "...people routinely move from negative affects through the neutral affect to positive affects" (Wachtel, 2019).

The following are suggestions that may contribute to restoring self-esteem. Clients need to remember shaming events. The feelings generated by these events and the assumptions that were made about them need to be recalled. Sometimes writing about them may help. As the events and assumptions are recalled, a client should be helped to think realistically about whether they were correct and fit reality. The following are possible questions for a client: Were you really at fault for the indifferent, neglectful, or rejecting behavior of a parent? Was your assumption of self-blame truly justified? What were the facts of the situation? What was the developmental history of each of your parents? What was their relationship with their parents? Is there a family history of substance abuse or emotional problems? Did your parents have a history of substance abuse or dysfunctional emotional responses and behavior? Do you have a history of being physically or emotionally abused? How did your parents relate to each other? Were your parents divorced when you were young? Was there a period of separation from your mother or family? Were you ever legally removed from your parents or placed in a foster home? These are some examples of questions that might aid in a review of experiences. The feelings of these experiences are stored in the brain and may be responsible for a client's self-critical inner voice and

spontaneous negative self-thoughts that inhibit self-esteem.

If a client has had any of the above experiences, they should be helped to think realistically about assumptions and feelings. Differentiating adult feelings from child feelings and developing a different perception of the experiences may then occur. This will promote a different and more realistic concept of self. It may free a client from negative feelings, including guilt or shame. This also is a way of improving and maintaining self-esteem. Another way to increase self-esteem is for clients to stop comparing themselves to others. Suggest that clients think of their uniqueness, strengths, and skills and give themselves credit for these attributes. They should focus on the positives about themselves and their accomplishments.

Suggest that clients forgive and forget mistakes of the past. Clients could be reminded to associate with others who share their values. They could be encouraged to educate themselves professionally or technologically. If they are married and have problems, they might be helped by professional intervention.

Religious beliefs and practices are another way to achieve and maintain self-esteem. Religiosity is significant in mental health and overall coping mechanisms that contribute to successful adaptation and social functioning. The link between religious belief and a positive self-esteem is real (Briggs, 2017). It can be safely inferred that self-worth and self-esteem are integral parts of a positive self-concept that may be the result of religious beliefs and practices.

It is safe to state that a feeling of self-esteem is related to a sense of being a good person. For clients who have religious beliefs and practices, one way to measure this sense of goodness is following the Commandments that are rules of conduct. There is an aspect to the Commandments that can be quite comforting whether one believes in God. Many emotional and relationship problems arise from a lack of structure for behavior that the Commandments as rules can provide. The first three Commandments refer to God, but the last seven set limits on human behavior. They concern respect for parents, stealing, killing, false statements about others, adultery, and taking another's goods or wife. All of these are serious transgressions that cover behaviors that require rules that are part of structure. If one behaves according to the Commandments, it is reasonable to believe

**A care manager's assessment should include an evaluation of guilt and shame.
Knowing how much these feelings affect a client's adaptation and social functioning will
contribute to developing a strong care management plan.**

that behavior will be normative and self-esteem will be maintained. The Koran, the sacred book of Islam, has reference to Commandments. These rules for behavior are part of Christianity, Judaism, and Islam (Elias, 2016).

Another possible way of increasing and sustaining self-esteem is through prayer. Prayer is an individual matter. There are formal prayers in every religious belief system. There also are informal prayers that are infrequently verbalized but silently expressed. Research about prayer and its effect on the brain has suggested that prayer affects the brain in positive ways (Newberg, 2014).

These are additional suggestions that may be given to clients about increasing self-esteem. The goal is to instill a positive sense of human agency in clients. The first idea is to think clearly about your accomplishments and strengths and give yourself credit for them. Do something that demonstrates your creative capacity. Give up feelings of past failures and concentrate on doing your best. Don't worry about what others think about you because their thoughts are their own and their behavior often is a projection of their thoughts. Do not associate with negative people. Set reasonable short-term goals for yourself and focus on achieving them. Reflect on your values and make changes in accordance with them. Set boundaries on your relationships so others cannot manipulate you. Eat appropriately, get enough rest, and maintain your personal appearance.

Summary and Recommendations

The purpose of this article was to highlight guilt and shame as factors in emotional distress that clients may hide from their care manager. The generation of guilt and shame and ways to manage these feelings were discussed. Care managers should ask clients about them. If these feelings are not discussed, intervention may be less effective. Clients often do not want to talk about these feelings because bringing them to consciousness increases their intensity and emotional pain. A care manager's assessment should include an evaluation of guilt and shame. Knowing how much these feelings affect a client's adaptation and social functioning will contribute to developing a strong care management plan. **CE**

CE exams may be taken online!

Click the link below to take the test online and then immediately print your certificate after successfully completing the test.
Members only benefit! This exam expires July 15, 2021.

Take this exam online >

Members who prefer to print and mail exams, [click here](#). You must be an ACCM member to take the exam, [click here to join ACCM](#).

References

- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Oxford, England: International Universities Press.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY, US: Basic Books.
- Briggs, D. (2017). Religion and science: How faith can boost self-esteem. Retrieved from: www.huffpost.com > entry > religion-and-science-how-...
- Director (2017). Director, Author at San Francisco Counseling Center. Retrieved 11/29/20 from: <https://www.sfcounselingcenter.com/author/director>.
- Elias, A.A. (2016). The Ten Commandments in Islam | Faith in Allah. Retrieved 11/20/20 from: <https://abuaminaelias.com> > ten-commandments-in-islam
- Elison, J., Lennon, R., & Pulos, S. (2006). Investigating the compass of shame: The development of the compass of shame scale. *Social Behavior and Personality: An International Journal*, 34(3), 221-238.
- Elison, J., Garofalo, C., & Velotti, P. (2014). Shame and aggression: Theoretical considerations. *Aggression and Violent Behavior*, 19(4), 447-453.
- Ellis, A., & Ellis, D. J. (2011). *Theories of psychotherapy. Rational emotive behavior therapy*. Washington, DC, US: American Psychological Association.
- Formica, M.J. (2008). Negative self-perception and shame. *Psychology Today*. Retrieved 11/6/20 from: <https://www.psychologytoday.com/us/blog/enlightened-living/200807/negative-self-perception-and-shame>
- Grille, R. & Macgregor, B. (2016). "Good" children - at what price? The secret cost of shame. Retrieved 12/12/20 from: https://www.natural-child.org/articles/robin_grille/good_children.html
- Koenig, H.G. & Larson, D.B. (2009). Religion and mental health: Evidence for an association. *Prevention in Human Services* 9(2), 67-77.

References continue on page 35

Patient-Centered Care Using Patient Perspective to Address the Social Determinants of Healthcare to Reduce Readmissions

Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, and Ellen Walker, MSW, LCSW, ACSW

“Potentially preventable readmissions” have been connected to insufficient or ineffective discharge strategies. Case managers have long made the connection between social determinants of health (SDOH) and increased risk for readmission through anecdotal observation. Failure to create overarching strategies to address the gaps caused by SDOH continues to impact the care continuum’s ability to adequately equip the patient for success postdischarge.

Social Determinants of Health

According to the Centers for Disease Control and Prevention (CDC), SDOH are the conditions where people live, work, play, learn, and worship that affect health and health outcomes (Centers for Disease Control and Prevention, 2018). These factors include:

- Quality healthcare
- Employment
- Insurance coverage
- Resources
- Safe environment/housing
- Transportation
- Education
- Income
- Freedom from racism/discrimination/segregation

SDOH have a tremendous impact on an individual’s health regardless of their age, race, or ethnicity. Only 20% of an individual’s health is tied to clinical care, which includes access to and quality of health care services. Eighty percent of an individual’s health is tied to their physical environment, SDOH (where they live, work, and play), and behavioral factors (eg, exercise or smoking).

More specifically, 80% of an individual’s health can be broken down as follows:

- roughly 40% is attributed to socioeconomic factors
- 10% is attributed to physical environment
- 30% is attributed to health behaviors

Eighty-six percent of current healthcare spending is related to chronic conditions, and \$1.7 trillion is spent on 5% of patients and is associated with SDOH

- \$35 million in excess care costs

- \$10 billion in illness-related lost productivity
- \$200 billion related to premature deaths
- \$26 billion related to readmissions
- Uncompensated care costs: unknown impact

We know that place and health are inextricably linked. That where you live impacts how you live. Improving health cannot be addressed disease by disease but must be informed by a comprehensive understanding of the wide range of factors that shape health status. We have established that place matters in concept. Where we live can determine how well we live and is a significant factor associated with life expectancy. Current life expectancy data demonstrates the range in life expectancy among counties in the United States; in some cases, the difference can exceed 20 years. For example, life expectancy rates are lower in southern states than they are in northern states.

People thrive when parents earn living wages, when children can get a quality education and have easy access to safe parks, and when grocery stores sell fresh produce. Families cannot thrive in unhealthy environments. People living in communities with walking paths and parks are more active than those who not have access to walking paths and parks. When people have access to healthier foods, they make healthier choices; in addition, providing new or improved local grocery stores can also improve local economies and create jobs.



Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, is the Director of Inpatient Care Coordination for Cook County Health System. Prior to this role, she piloted quality improvement initiatives focused on readmission reduction, care coordination through better communication, and population health management. She has over 20 years of nursing experience, and her clinical specialties include medical/surgical, oncology, and pediatric nursing.

Ellen Walker, MSW, LCSW, ACSW, has been the social work manager at West Suburban Medical Center in Oak Park, Illinois, for the past 3 years and has worked there as a social worker for the past 26 years. Her past experiences also include working as crisis worker for a teenage crisis agency and her internship at Hines VA.

Case managers have long made the connection between social determinants of health and increased risk for readmission through anecdotal observation.

All community environments are not created equal when it comes to opportunities for healthy living. Low-income and communities of color are more likely to lack health-promoting infrastructure and resources. More people are recognizing the impact that chronic diseases such as diabetes and obesity, which are often preventable, are having on their communities and want to do something about it to change the health of their families, communities, and constituents. This movement recognizes that healthy people and healthy places go together. The growing movement for healthy communities—with its push for changes in the physical, economic, social, and service environments—holds great promise.

Healthy People Program

Healthy People 2030 is the fifth edition of Healthy People. It aims at new challenges and builds on lessons learned from its first 4 decades. The initiative began in 1979, when Surgeon General Julius Richmond issued a landmark report entitled *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. This report focused on reducing preventable death and injury. It included ambitious, quantifiable objectives to achieve national health promotion and disease prevention goals for the United States within a 10-year period (by 1990). The report was followed in later decades by the release of the updated 10-year Healthy People goals and objectives (Healthy People 2000, Healthy People 2010, and Healthy People 2020).

Healthy People 1990–2020

The original Healthy People program in 1990 created overarching goals of decreasing mortality rates from infancy through adulthood and increasing independence for the older adult population. The 1990 version featured 15 topics areas and 226 objectives/measures. The 2000 update was the first iteration to include “reduction of health disparities” as an overarching goal and a specific goal of “achieving access to preventive services for all” with 22 topic areas and 312 objectives/measures. Healthy People 2010 increased the topic areas to 28, and the objectives/measures addressing the new goal of “elimination of health disparities” increased to 1000, a significant increase given the scope of the work needed to achieve that specific goal.

Health People 2020 goals speaks to “attaining high-quality,

longer lives, free from preventable disease; achieving health equity and eliminating disparities; creating social and physical environments that promote good health and promotion of quality of life, healthy development and healthy behaviors across the life span”. The goals were addressed by 42 topic areas and over 1,200 objectives/measures (Healthy People 2020).

Healthy People 2030 Goals: Increased Focus on SDOH

Healthy People 2030 continues to build on the themes of decreasing and eliminating disparities. The goals include:

- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The eHealth Initiative notes that by integrating SDOH into care plans, “Healthcare stakeholders can recognize the need for, and enable access to, additional services or interventions for individuals” (eHealth Initiative, 2019). The most impactful word in this statement is “individuals.” One size does not fit all and thus each care plan must be developed with the patient’s input and insight to be fully impactful. After all, these are the patient’s goals.

Patient-Centered Care

The Institute of Medicine defines patient-centered care as “providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions” (HealthLeads, 2018). Patient-centered care is characterized by a true partnership between individuals and their healthcare providers, where the patient’s needs drive the plan and how success is measured.

To give true patient-centered care, healthcare providers need to know not only patient’s preferences but their

Social determinants of health have a tremendous impact on an individual's health regardless of their age, race, or ethnicity. Eighty percent of an individual's health is tied to their physical environment, social determinants (where they live, work, and play), and behavioral factors (eg, exercise or smoking).

perspectives on healthcare. "Despite the emphasis of the literature on the value of the patient perspective, the concept of the patient perspective is unclear, as are the aspects of the patient perspective that need to be addressed in the conversation. Indeed, the notion of the patient perspective remains vague and fragmented" (Zanini, et al, 2014). Having an understanding of what the patient experiences from their point of view is key to developing individualized, comprehensive care plans in which mental health and social needs receive equal attention to traditional medical treatment. As we know, this has proved to be challenging and has been identified as a leading cause of avoidable readmissions.

The Intersection of SDOH and Patient-Centered Care

Healthcare professionals can use SDOH to determine which patients need stronger provider outreach and to understand a patient's individual circumstances, the resources that are available for this patient, and their feelings about the issues they face on a daily basis. For example, this information may cue a provider to refer the patient to certain social services that can help the patient address social issues such as housing or food insecurity. Reducing the stressors surrounding where the patient will safely live or when they will have access to their next meal can allow them to focus more time and effort on obtaining a better understanding of their health risks and strategies to address them more fully. This understanding gives providers another starting point for meaningful conversation and interaction with the patient to identify gaps across the healthcare and social continuum and to build a better patient-centered plan of care.

The Journey Starts: 2009

In 2009, as a newly minted acute care case management director, readmission prevention was new buzzword phrase and major focus for the department and facility. My first task was to try to get a handle on the "why" of readmissions. Believing that that patients may feel more comfortable to discuss "discharge plan failures" in their own environments, I decided to call our readmitted patients upon discharge. I completed six calls on one particular day, and I was surprised to hear about the issues that our patients were facing postdischarge. Reviewing their discharge planning assessments, these patients were identified as low risk; all were

discharged home, required no supportive medical services, and were connected with their primary care provider with postdischarge appointments in place.

Patient follow-up appointments within 7 days of acute discharge is the gold standard for good ongoing health management. Making the appointment for the patient was only one part of the equation. Could the patients get to and from their postacute appointment? Were we even asking about this? The postdischarge appointments were made before discharge but most patients reported being unable to attend the appointment. In the suburban/almost rural area with scarce public transportation resources, the patients identified this as a significant barrier to their ongoing healthcare management. Transportation to and from provider appointments was an identified issue.

Access to medications within 24 hours postdischarge was also an identified issue; similar to the patients' ability to attend their follow-up appointment, this was a transportation issue. They simply could not get to the local outpatient pharmacies to drop off their prescriptions and pick up the filled medications. Another gap in care that we weren't even asking about.

Obviously, discharge planning needed to evolve and adapt to do a better job of including these nonmedical points that had a serious impact on patients' ability to take care of themselves after discharge. Simple fixes, such as including new questions targeted to the gaps we identified during these and subsequent calls, helped to gather data on the actual impact these gaps created. Using that information, we created programs and partnerships to address them.

We worked with the hospital-based pharmacy to send patients who were identified as having difficulty obtaining their medications in a timely manner to ensure that these patients went home with their medications in hand. Our volunteer department chipped in to deliver medications to patients' homes in cases where patients needed to use specific community-based pharmacies.

Providing taxi vouchers for patients in need of transportation to and from provider appointments was another simple, yet costly solution. However, in the face of recurring readmissions, potential nonpayment of cost of care, and year-end penalties, providing access to transportation was the more cost-effective solution.

Patient-centered care is characterized by a true partnership between individuals and their healthcare providers, where the patient's needs drive the plan and how success is measured

2013: Another Perspective

After taking on the role of Director of Case Management at an acute care hospital in Chicago's inner city, I had the opportunity to work with a new patient population and, therefore, I had a new patient perspective compared with my previous place of employment. Evaluation of readmitted patients and their reasons for readmission (obtained through patient interviews) brought an unusual pattern of behavior to light. In a 1-year period, the hospital experienced 676 Against Medical Advice (AMA) discharges, which accounted for over 11% of all discharges. Of these 676 patients, 129 were readmitted. This gave the hospital a readmission rate for AMA discharges of 18.25%. Further evaluation through patient interviews demonstrated that the reasons for patients "going AMA" were distributed as follows:

Twenty-five percent were attributed to SDOH such as lack of child care, unstable housing situations, domestic violence issues, family emergencies, and the need to attend methadone clinic appointments in a timely manner. These patients would need to reapply to their methadone programs if they missed 3 consecutive days of attendance, regardless of reason, and would end up back on waiting lists for treatment. Thirty-six percent of AMA discharges were related to potential substance abuse issues, fear of withdrawal, or the patient not being engaged in entering treatment for substance abuse disorder. The remaining 39% of AMA patients declined to give a reason for their decision to "go AMA."

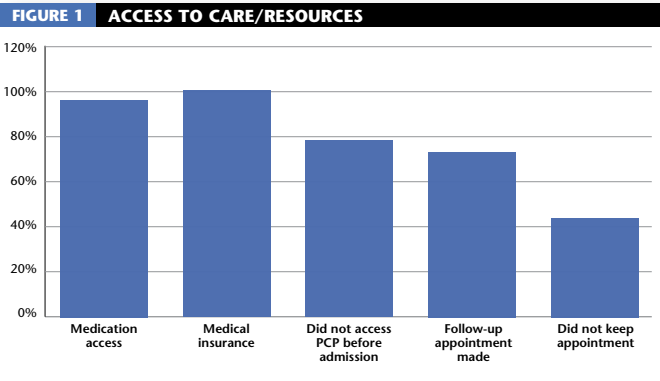
One difference between the 2009 group of patients (suburban/rural, middle- to lower-middle income, 85% insured) and the 2013 group of patients (urban, 90% uninsured/underinsured) was that transportation was a key factor for the 2009 group but was not a factor for the 2013 group. Access to medication was a common theme between the two groups but not for the same reason. The 2009 group had the means to pay for their prescribed medications but lacked reliable transportation to get them. The 2013 group had ready access to transportation to get their medications but did not necessarily have the financial resources to pay for them. A solution was developed to ensure that all patients were discharged with a 30-day supply of all prescribed medications in an effort to bridge that access gap, regardless of ability to pay or insurance coverage.

2018-2019

A review of the literature demonstrates that addressing the patient "point of view" through survey of risk focused on SDOH has been successful at creating better linkage and access to care/services needed by patients to self-manage their health. Using a survey tool based on the PRAPARE survey (used in outpatient settings), case manager nurses and social workers at West Suburban Medical Center in Oak Park, Illinois, identified and addressed the patient's perspective for the reason for readmission: issues with access to care, resources, or gaps in self-management. One hundred eighteen patients who were readmitted over a 7-month period were interviewed when they were readmitted. They were asked a series of questions related to SDOH and their reasons for presenting to the hospital for readmission: Did they have access to medications within 24 hours of discharge? Was a follow-up appointment made before discharge? Were there any social issues impacting their ability to care for themselves? (A list was provided as conversation starters.) The final question was "Why do you think you became sick enough to come back to the hospital?" and used the Wasson/Coleman health confidence tool to evaluate the patient's perception of their ability to care for themselves after discharge.

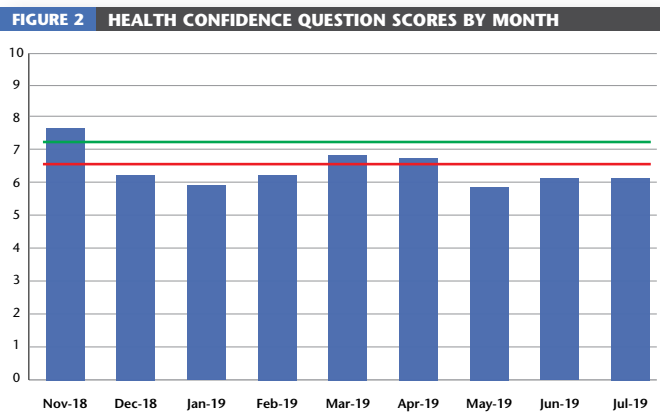
Significant conclusions from this data gathering and analysis showed that some SDOH issues (eg, medication access, access to insurance) have little impact on our readmitted patient population. Figure 1 demonstrates that 98% of patients had access to their medications within 24 hours of discharge and that 100% of patients had healthcare insurance, with varying levels of postacute care benefits.

When asked if they had called their primary care provider before coming to the emergency department, over 75% of interviewed patients answered that they had not sought advice from a provider before making the decision to come to the hospital. This lack of connection with primary care providers continued when we evaluated the attendance at post-acute follow-up visits to primary care providers. Seventy-eight percent of patients were discharged with a physician follow-up visit within 7 days. Over 40% of patients did not keep that appointment, and when asked why, most patients believed the follow up was unnecessary. A frequent comment was "I was just in the hospital and saw a lot of doctors, why do I need to see another one?"



Abbreviation: PCP, primary care provider.

Patients reported receiving discharge instructions consistently but did not appear to be engaged in the postdischarge plan of care or reported lacking the health confidence to carry out the plan of care, as demonstrated by an average health confidence score of 6.5/10 (Figure 2).



While this project was designed to identify the needs of the high-risk patient population, it can be easily adapted to any patient population. Recognizing that responsibility for the patient in this healthcare environment does not end at discharge from the hospital, conclusion of service, or end of the appointment, patients' extramedical needs and education opportunities that may impact successful self-management of health should be identified. In addition, it is necessary to draw from the resources of the patient's entire community to provide the patient with excellent patient-centered care and to promote client self-advocacy and independence in alignment with the Case Management Society of America's Standards of Practice.

The American Hospital Association recognizes that while providers regularly have conversations with patients

regarding their medical issues, discussions about patients' social needs and issues can be more sensitive and, therefore, challenging for both provider and patient. These types of conversations need to be focused by asking the "right" questions in the "right" way to engage the patient and bring forth their personal "story." Patients are more willing to share the details of their life circumstances when approached with compassion, openness, and empathy so that a safe, nonjudgmental atmosphere is created. This leads to a building of trust and better communication between provider and patient and the opportunity for true patient-centered care (American Hospital Association, 2019). Screenings need to be completed on every patient and at every encounter because a patient's circumstances can change between visits.

CE II

References

American Hospital Association (2019). Screening for social needs: guiding care teams to engage patients. www.aha.org.

Barnett M. (2009). Promoting self-management for patients with COPD. *Journal of Community Nursing*, 23(9), 4–10.

Center for Disease Control and Prevention (2018). Social determinants of health: know what affects health. www.cdc.gov/socialdeterminants

eHealth Initiative (2019). Guiding principles for ethical use of social determinants of health data. www.chidc.org

HealthLeads (2018). Patient-centered care: elements, benefits and examples. <https://healthleadsusa.org/resources/patient-centered-care-elements-benefits-and-examples/>

Mitchell, S. E., Laurens, V., Weigel, G. M., Hirschman, K. B., Scott, A. M., Nguyen, H. Q., Li, J. (2018). Care transitions from patient and caregiver perspectives. *Annals of Family Medicine*, 16(3), 225–231.

Wasson, J & Coleman, E. (2014). Health confidence: a simple, essential measure for patient engagement and better practice. *Fam Pract Manag*. 2014 Sep-Oct;21(5):8-12.

Zanini, C., Sarzi-Puttini, P., Arzeni, F., DiFranco, M. and Rubinelli, S. (2014). Doctor's insight into the patient's perspective: a qualitative study in the field of chronic pain. *BioMed Research International*, Vol 2014, Article ID 514230.

CE exams may be taken online!

Click the link below to take the test online and then immediately print your certificate after successfully completing the test.
Members only benefit! This exam expires July 15, 2021.

Take this exam online >

Members who prefer to print and mail exams, [click here](#). You must be an ACCM member to take the exam, [click here to join ACCM](#).

Defining Values to Improve Culture, Job Satisfaction, and Decision Making

Shanna Huber, BSN, MSN/Ed, RN, CCM, CLCP, CNLCP, CMC

Values are the fundamental beliefs of a person or an organization. If asked about values, an individual may have some idea of what they hold dear to their heart, such as family, work-life balance, or honesty. Or they may refer to “family values,” which are cultural or moral values. These may include working hard, respect, or responsibility. However, few people and organizations define their core values. By defining core values and having clear value statements, care managers and organizations can influence work culture, increase job satisfaction, and improve the decision-making process.

Some decisions are easy to determine if they are in alignment with your values and considered ethical decisions. Other decisions may take some time to

evaluate, and there may be gray areas. In these instances, the care manager may go through a process that will be more difficult if values are not well defined. The Commission for Case Manager Certification® (CCMC/CDMS) has ethical standards of practice and a code of professional conduct, which become general rules to follow or guide best practice. Whether your working title is case manager or care manager, understanding the impactful interplay of ethics and values will help you navigate your often-complex role when assisting individuals and families. This article will discuss the process of defining personal core values, creating and defining organizational core values, and incorporating these values in difficult decisions care managers are often faced with within the work environment.

standards relevant to their specific area of practice and licensure as well as organizational standards that are set forth by the organization.

Care managers, especially those in private practice, will undoubtedly encounter ethical dilemmas and situations. Care managers typically have more autonomy than other professions and often face health decisions that tend to have gray areas. “Confident, professional care managers working within their scope of practice using a reliable, consistent, quality approach, with an adherence to industry standards of practice and code of ethics, will find their work fulfilling and their practice resilient” (Crowley & Huber, 2021).

Defining Personal Values

If organizational values are not aligned with personal values, the care manager will most likely have poor job satisfaction and they may not know why they are dissatisfied with work. Or it may be more obvious. For example, if leadership makes contested decisions, if there is some sort of operational conflict due to disagreement, or if team members differ in their response to situations or in the way processes are applied in difficult cases. Influences such as faith, politics, and upbringing will impact the individual and group response to events or situations. For employees, defining core values and finding work within an organization aligned with their values and beliefs is often the key to greater job satisfaction and fulfillment.

Care managers and individuals have



Shanna Huber, BSN, MSN/Ed, RN, CCM, CLCP, CNLCP, CMC, has been a registered nurse for 25 years. She is the owner of *Ripple Life Care Planning*, a private care management

practice, and owner of *My Junna Software*, a client management software for care managers who need a system dedicated to their specific needs. Shanna and coauthor **Jennifer Crowley, BSN, RN, CLCP, CADDCT, CDP, CMC,** recently published the *Life Care Management Handbook for individuals who want to start or grow a private care management practice*. They recently launched the *Life Care Management Institute*. To learn more or purchase the book go to www.lcmexpert.com.

Ethics

Ethics are rules and guidelines within a culture, organization, or profession. While values can change due to individual beliefs, ethics are more defined and consistent within a particular context. Many professions and organizations have ethical standards of practice, which are a written document to serve as a guide for those who would follow them (Encyclopedia.com, 2021). According to the International Association of Life Care Planners, the primary goal of ethics in practice is to protect clients, provide guidance to professionals working in the field, and enhance professionalism (Crowley & Huber, 2021). Care managers should be familiar with all professional practice

LIST 1 LIST OF VALUES

| | | | | |
|---------------|------------------|------------|-----------|------------|
| Hope | Loyalty | Power | Wealth | Competence |
| Trust | Open-minded | Tradition | Success | Fairness |
| Honesty | Selfless service | Health | Education | Faith |
| Family | Courage | Balance | Fun | Kindness |
| Dependability | Love | Creativity | Laughter | Wisdom |
| Friendship | Peace | Comfort | Humility | Openness |

many values, but core values are the top values that individuals consider most important. Defining core values will help the care manager decide which values are the most important.

For this exercise, circle the top five values that are most important to you at this time (List 1). If you do not see a value on the list, write in your own.

After you circle five items, write down the top three and combine any that are very similar. These are your core values.

Creating Organizational Values

In care management, ethics are fundamental because they have more room to shape practice than in other healthcare areas. It is incumbent on care managers to determine their organization's values, train their teams internally to align with those values, and bring an attitude of openness and cultural humility to the vulnerable communities they serve.

Leaders, managers, and business owners can be a part of defining and creating organizational work values. When organizational values are clear, it attracts like-minded individuals to the job and creates job satisfaction. If you are in a leadership role and know the organizational values, be sure that they are well defined and shared across the organization. If you do not know what the organizational values are, it is time to create them! If you cannot

create them for the whole organization, developing values for your department, unit, or team will build leadership and guide employees.

Ensuring alignment of organizational values among top management team members may be critical to reducing dysfunctional relationship conflict within the team and promoting positive attitudes among team members (Lankau et al., 2007). Professional codes of conduct, such as the CCMC Professional Code of Conduct and the CDMS (Certified Disability Management Specialist) Code of Professional Conduct, play a role in work fulfillment. Although professional ethical values play a role, organizational values play a larger role because culture and the environment are a part of daily

work life (Somers, 2001). It is essential to have separate organizational values to help define this culture and assist in finding employees who fit into the culture of the organization.

The process of creating organizational goals involves gathering the key leaders in the organization or a department. This process can also relate to a small team-based group or used in a start-up care management practice to provide a foundation for sustainable and effective decision-making. Create a list of organizational values (List 2). These are similar to personal values. Some ideas to get you started are below.

In an organization, share this list with all the team members involved during a team meeting. Have members add to this list. Once the list is complete, and everyone's input is gathered, each person should choose their top three values. Start a new list with just those values and have all members discuss them, selecting the top three to seven values.

One important thing to understand is that core values typically already exist within an organization and are usually lost in the day-to-day chaos. This task is merely a matter of rediscovering what they are and instilling them as a rule to play by (Wickman, 2011).

LIST 2 LIST OF ORGANIZATIONAL VALUES

| | | | | |
|---------------|------------------|------------|------------|----------------------|
| Trust | Loyalty | Health | Laughter | Kindness |
| Honesty | Open-minded | Creativity | Humility | Does the right thing |
| Family | Selfless service | Comfort | Competence | Accountability |
| Balance | Courage | Conformity | Growth | Growth-oriented |
| Dependability | Power | Education | Fairness | Integrity |
| Support | Tradition | Fun | Faith | Teamwork |

By defining core values and having clear value statements, care managers and organizations can influence culture, increase job satisfaction, and improve the decision-making process.

Value Statements

One study found only that 8% of study participants reported that their organizations had a formal code of ethics. This finding was a sharp contrast to previous research that found that 75% of American organizations had adopted a corporate code of ethics. Additional studies found that 42% of study participants were “not sure” if their organization had adopted a code of ethics (Somers, 2001).

Organizational values should not be kept in a binder somewhere in the office, hidden from customers and employees alike. To hold everyone accountable, values should be clear and easily understood by employees, customers, and leaders. Choosing core values is just the first step. To ensure the values are lived by and develop a culture within the organization, they must be crystal clear.

The next step in creating a culture of shared values and further defining values is creating value statements. These statements are how the organization and employees will respond to certain circumstances, make decisions, and be held accountable for their actions. List out the core values and write clear statements of expectations. Some examples are:

Value: Fairness

Statement: For each thing we do, we consider the fairness of the patient, organization, and employee.

Value: Education

Statement: Each member will be responsible for continuing education each year to improve their practice. We will

support each team member by allowing them to take 3 days off for conferences or continuing education.

Value statements should be well known throughout the organization. Some ideas to promote organizational values includes:

- Framing value statements in the workplace where they are visible by all
- Recognizing employees who exemplify a work value such as “employee of the month” or having another way to raise awareness and identify key role models
- Publishing an employee newsletter that reflects organization values and standards provides a mechanism for acknowledging actions that support the core organizational values and offer growth opportunities.
- Establish perks employees can take advantage of, which creates a culture supporting the value. Examples may include valuing social justice, giving back to the community, or working for a worthy cause. Giving each employee time off for volunteering each year may be an option; other examples include organizing a charitable event, creating opportunities for donating, serving a greater need, or making a worthy contribution.

Do Your Personal Values and Organizational Values Align?

An organization with transparent and well-defined values improves employee satisfaction. It also helps employers make hiring decisions for individuals who align with their organizational values. For optimal job satisfaction, care managers who are seeking employment should evaluate the company’s values with their personal values. An

organization that values success only by the number of hours an individual puts into their work and that confines individuals to a rigid work schedule may fall short of meeting the values of an individual who values work-life balance and prefers a more flexible schedule based on quality of work rather than quantity. The same may be true for an organization that values teamwork versus a highly competitive individual who has difficulty sharing decision-making or generally does not enjoy teamwork. The competitive individual may not be a great fit for the organization that values teamwork.

Guiding Principles: Ethics, Values, and Professional Standards of Practice

The same open attitude, curiosity, and commitment to quality of life that care managers bring to each client’s care will serve them well in supporting patients (Crowley & Huber, 2021).

Somers (2001) found that organizations that promoted ethical behavior reap several vital benefits including less wrongdoing and higher levels of employee commitment. The contextual perspective used in this study indicates formal ethical codes are a component that encourages and supports higher ethical behaviors, and there are formal and informal mechanisms to ensure that ethical conduct becomes a “way of life” (Somers, 2001).

Professional Code of conduct:

In the CCMC and CDMS Code of Professional Conduct, there are a set of principles, rules of conduct, and scope of practice, which also have underlying values. It is stated in this

Whether your working title is case manager or care manager, understanding the impactful interplay of ethics and values will impact your ability to navigate your often-complex role when assisting individuals and families.

code of conduct that when confronted with ethical dilemmas, case managers must abide by the code as well as by the professional code of ethics for their professional discipline for guidance and support (CCMC, 2015 and CCMC, 2019). Underlying values outlined in the CCMC/CDMS Code of Professional Conduct include:

- CCMs/CDMSs believe that case management is a means for improving client health, wellness, and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.
- CCMs/CDMSs recognize the dignity, worth, and rights of all people.
- CCMs/CDMSs understand and commit to quality outcomes for clients, appropriate use of resources, and empowerment of clients in a manner that is supportive and objective.
- CCMs/CDMSs embrace the underlying primes that when the individual(s) reaches the optimum level of wellness and functional capability, everyone benefits: the individual(s) served, their support systems, the health care delivery systems, and the various reimbursement systems.
- CCMs/CDMSs understand that case management is guided by ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity.

The case manager may have multiple codes of ethics for their profession based on other licenses and certifications. The case manager should be familiar with and regularly review their professional codes of ethics to ensure practice adherence.

Decision Making Based on Ethics, Values, and Professional Standards of Practice

An organization can make many decisions based on core values. When building a team and organization, hiring decisions based on values helps create a culture, leading to improved decision-making. Research has shown that the outcomes of a decision process can be affected dramatically by the characteristics of the team and its members (Lankau et al., 2007). Organizational values are supposed to influence decisions made by employees at all levels regarding daily practice and personal interactions (Lankau et al., 2007).

Ethics guide us in what is right or what is wrong, whereas values guide us in what level of importance we give them. Both are important when making decisions, which are sometimes tricky when coming across situations that may not have an immediate, straightforward, right, or wrong decision. When a care manager comes across such a decision, a way to ensure a good outcome is going through a series of questions:

1. Is the decision within the scope of my professional organization's standards of practice?
2. What do my organizational values or ethics say about this situation?
3. What are my personal values, and how do they align with this decision?

Case Study

Kathy never imagined being unable to take care of her husband, John, through old age. She was 13 years younger than her husband. But Kathy developed significant health problems,

which landed her in a nursing home, unable to return home again. Because John had dementia, she was faced with the dilemma of finding appropriate care for him while ensuring her own care needs were met. Eventually, with the help of a care manager, she was able to hire outside help and transition him to memory care once his dementia progressed. Having two household members requiring long-term care was a financial challenge. Choices were limited, and the situation caused great concern and despair for the couple and their family.

Kathy and John were living nearly 30 miles apart in two different residential facilities. Because John was a veteran, he qualified for care in the state-run home for veterans. Although there was a long waitlist, and she was not a veteran, Kathy applied for the same home, hoping eventually that she could share a room with her husband. The admission staff said that it could possibly take a year or longer for Kathy to get a room with her husband.

Kathy spoke to her husband almost daily. She began to hear him repeat himself, ask about her whereabouts, be oblivious to the time of day, and have no memory of leaving his home and becoming a resident of the facility where he now lived. Kathy sensed he was happy but became worried when he spoke of loving another woman, a resident at the same facility. John could no longer establish a marital connection with his wife when they spoke on the phone. He spoke like a juvenile who was talking about his heartthrob: his voice was excited, and he was unaware of the pain that he was inflicting on his wife and the ethical dilemma he had created.

Care managers should determine their organization's values, train their teams internally to align with those values, and bring an attitude of openness and cultural humility to the vulnerable communities they serve.

Shortly thereafter, an opening at the Veterans Home became available, making it possible to move Kathy to the home and occupy the same room with her husband. The arrangement would only work if she were the “healthy brain” to keep an eye on things while he was the “healthy body” to assist her with the little things that made her life easier. She could barely use her arms because of a lack of coordination and severe, chronic weakness. But she was alert, capable of decision-making, and she could speak her mind.

If the arrangement did not work, she would be alone in a different wing while her husband was confined to a lockdown unit. She also worried if her bedridden state would affect him, if she would be responsible for too much, or if she would be forced to witness a loved one progress to end-stage dementia. Then there was the “girlfriend.” Turning to her spiritual learning from her younger years, she believed that her husband's happiness was more important than the formal acknowledgment of their marriage. She hoped that his last days would be joyful, she valued forgiveness, and she was flexible and open-minded. She managed to find humor in the situation and the courage to ask staff to help figure out what was best.

The staff was able to use a pragmatic approach, recognizing the difficulty of allowing individuals the freedom to make choice while reducing the potential for harm. They were already aware of the budding relationship between John and the other female resident and came up with a plan to move his room to a different wing altogether. Everyone was thankful when his only response was to forget

that anything had happened at all, although the staff did not struggle with the right thing to do at the time and leaned on the administration's guidance to help navigate the situation. The administration provided little guidance. There was no policy and no documentation of similar cases; it was a gray area dependent on everyone's reaction to the events unfolding.

Unfortunately, the difficulty did not end there with Kathy and John. Kathy was decades younger than the other residents, but eventually her severe physical limitations became a heavy burden. Kathy was a sharp individual who cracked jokes but who also called out staff members when they forgot to respond to her requests or fell short of providing high-quality care. She became increasingly frustrated. Some staff said she was too difficult to take care of.

Kathy had discussed her end-of-life wishes and how she did not want the staff to take heroic measures if she became critically ill. She verbalized that she would seriously consider a withdrawal of care to allow natural death if she was still dependent on life-saving dialysis. The care manager knew the importance of advance care planning and had the wisdom and experience to bring up the complicated topic of end-of-life care.

After some time, Kathy became aware that John no longer could identify her as someone who was important in his life. She became just the “roommate”. John went about his day mostly happy and content. He listened to Kathy's music and followed her instructions when necessary, but he mostly lacked any emotional attachment to

Kathy. On days when she underwent dialysis, he often did not realize she had been gone for several hours. He no longer contributed to any decision-making and became increasingly indifferent to the world around him.

Kathy became more accepting of her fate, stating a desire to stop the dialysis treatments. She explained her wishes to staff, who questioned the integrity of her decision-making. Reaching out to the care manager for assistance, the staff stated their concerns for a mental health evaluation, suggesting Kathy was not in her right mind and could not make such a decision. Having remained involved in providing oversight and support to Kathy, the care manager was keenly aware of Kathy's current condition, including her full capacity for decision-making, and the care manager reviewed past conversations about Kathy's intentions for end-of-life care. Kathy had completed legal documents highlighting these wishes to not rely upon life-sustaining care if her condition did not improve. It was not easy for most of the staff who were involved with Kathy's care to be aligned with her wishes. Still, it did stimulate many conversations, which helped staff and family to consider their values and beliefs given the circumstances.

Eventually, hospice was ordered for Kathy. The devoted hospice team acknowledged Kathy's decision to withdraw dialysis, knowing she would only live a few weeks, if that. The hospice team created an environment of peace, acceptance, and comfort for all involved. Ethically, they owed it to Kathy to honor her wishes and respect her freedom to choose her own health

care. Along with a physician's support and medical order, they aligned their company values with Kathy, providing dignity with death.

The reader might be concerned about Kathy's husband and about the staff, which was left with no choice but to allow Kathy to give up dialysis and create a plan for death. Most likely the staff had a lack of knowledge about dementia, a lack of guidance from leadership, and conflict from their own upbringing; Kathy's wishes to stop dialysis were simply a gray area for many of the staff.

It takes intention and thoughtfulness to understand individual values and how might they apply to real-life scenarios. Care managers and case managers handle complex situations daily, having to come to terms with their own values, beliefs, and identified responses to ethical dilemmas. Through personal and professional development, discovery of personal

values, and relying organizational values and professional standards of practice, navigating difficult and unique situations can be more manageable. **CE III**

References

Commission for Case Manager Certification (CCMC). (2015). Code of professional conduct for case managers: with standards, rules, procedures and penalties. Retrieved from https://ccmcertification.org/sites/default/files/docs/2017/code_of_professional_conduct.pdf

Commission for Case Manager Certification (CCMC). The CDMS Code of Professional Conduct, Mount Laurel, NJ. 2019.

Crowley, J. & Huber, S.S. (2021). *The Life Care Management Handbook*. Author Academy Elite.

Encyclopedia.com (2021). Ethics: an overview. Retrieved from <https://www.encyclopedia.com/finance/finance-and-accounting-magazines/ethics-overview>

Lankau, M. J., Ward, A., Amason, A., Ng, T., Sonnenfeld, J. A., & Agle, B. R. (2007). Examining the impact of organizational value dissimilarity in top management teams. *Journal*

of Managerial Issues, 19(1), 11+. <https://link.gale.com/apps/doc/A163940477/ITBC?u=uphoenix&sid=ITBC&xid=4f82a6b1>

Somers, M.J. (2001). Ethical codes of conduct and organizational context: a study of the relationship between codes of conduct, employee behavior and organizational values. *Journal of Business Ethics*, 30(2), 186-195. <https://doi.org/10.1023/A:1006457810654>

Wickman, G. (2011). *Traction: Get a Grip on Your Business*. Bonbella Books, Inc.

CE exams may be taken online!

Click the link below to take the test online and then immediately print your certificate after successfully completing the test.

Members only benefit!

This exam expires April 15, 2022.

Take this exam online >

Members who prefer to print and mail exams, [click here](#).

You must be an ACCM member to take the exam, [click here to join ACCM](#).

Be Your Own Boss!
Life Care Management A-Z
Learn how to start & grow your own Care Management business!

- Practical skills & solutions
- Resources, strategies & tools
- A road-map to equip the Life Care Manager
- In-depth review of today's most challenging & complex issues to help the Life Care Manager succeed

Join our mailing list or purchase a book TODAY!
www.LCMexpert.com

PharmaFacts for Case Managers



Orgovyx

INDICATIONS AND USAGE

Orgovyx is indicated for the treatment of adult patients with advanced prostate cancer.

DOSAGE AND ADMINISTRATION

Recommended Dosage

Initiate treatment of Orgovyx with a loading dose of 360 mg on the first day and continue treatment with a 120 mg dose taken orally once daily at approximately the same time each day.

Orgovyx can be taken with or without food. Instruct patients to swallow tablets whole and not to crush or chew tablets.

Advise patients to take a missed dose of Orgovyx as soon as they remember. If the dose was missed by more than 12 hours, patients should not take the missed dose and resume with the next scheduled dose.

If treatment with Orgovyx is interrupted for greater than 7 days, restart Orgovyx with a loading dose of 360 mg on the first day and continue with a dose of 120 mg once daily.

In patients treated with GnRH receptor agonists and antagonists for prostate cancer, treatment is usually continued upon development of nonmetastatic or metastatic castration-resistant prostate cancer.

Dose Modification for Use with P-gp Inhibitors

Avoid coadministration of Orgovyx with oral P-gp inhibitors. If coadministration is unavoidable, take Orgovyx first and separate dosing by at least 6 hours. Treatment with Orgovyx may be interrupted for up to 2 weeks if a short course of treatment with a P-gp inhibitor is required.

Dose Modification for Use with Combined P-gp and Strong CYP3A Inducers

Avoid coadministration of Orgovyx with combined P-gp and strong CYP3A inducers. If coadministration is unavoidable, increase the Orgovyx dose to 240 mg once daily. After discontinuation of the combined P-gp and strong CYP3A inducer, resume the recommended Orgovyx dose of 120 mg once daily.

DOSAGE FORMS AND STRENGTHS

Tablets: 120 mg, light red, almond-shaped, film-coated, and debossed with "R" on one side and "120" on the other side.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

QT/QTc Interval Prolongation

Androgen deprivation therapy, such as Orgovyx may prolong the QT/QTc interval. Providers should consider whether the benefits of androgen deprivation therapy outweigh the potential risks in patients with congenital long QT syndrome, congestive heart failure, or frequent electrolyte abnormalities and in patients taking drugs known to prolong the QT interval. Electrolyte abnormalities should be corrected. Consider periodic monitoring of electrocardiograms and electrolytes.

Embryo-Fetal Toxicity

The safety and efficacy of Orgovyx have not been established in females. Based on findings in animals and mechanism of action, Orgovyx can cause fetal harm and loss of pregnancy when administered to a pregnant female. In an animal reproduction study, oral administration of relugolix to pregnant rabbits during the period of organogenesis caused embryo-fetal lethality at maternal exposures that were 0.3 times the human exposure at the recommended dose of 120 mg daily based on area under the curve (AUC). Advise males with female partners of reproductive potential to use effective contraception during treatment and for 2 weeks after the last dose of Orgovyx.

Laboratory Testing

Therapy with Orgovyx results in suppression of the pituitary gonadal system. Results of diagnostic tests of the pituitary gonadotropic and gonadal functions conducted during and after Orgovyx may be affected. The therapeutic effect of Orgovyx should be monitored by measuring serum concentrations of prostate specific antigen (PSA) periodically. If PSA increases, serum concentrations of testosterone should be measured.

ADVERSE REACTIONS

The clinically significant adverse reactions was QT/QTc Interval Prolongation.

DRUG INTERACTIONS

Effect of Other Drugs on Orgovyx

P-gp Inhibitors

Coadministration of Orgovyx with a P-gp inhibitor increases



the AUC and the maximum concentration (C_{max}) of relugolix, which may increase the risk of adverse reactions associated with Orgovyx. Avoid coadministration of Orgovyx with oral P-gp inhibitors.

If coadministration is unavoidable, take Orgovyx first, separate dosing by at least 6 hours, and monitor patients more frequently for adverse reactions.

Treatment with Orgovyx may be interrupted for up to 2 weeks for a short course of treatment with certain P-gp inhibitors.

If treatment with Orgovyx is interrupted for more than 7 days, resume administration of Orgovyx with a 360 mg loading dose on the first day, followed by 120 mg once daily.

Combined P-gp and Strong CYP3A Inducer

Coadministration of Orgovyx with a combined P-gp and a strong CYP3A inducer decreases the AUC and C_{max} of relugolix, which may reduce the effects of Orgovyx. Avoid coadministration of Orgovyx with combined P-gp and strong CYP3A inducers.

If coadministration is unavoidable, increase the Orgovyx dose. After discontinuation of the combined P-gp and strong CYP3A inducer, resume the recommended dose of Orgovyx once daily.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

The safety and efficacy of Orgovyx have not been established in females.

Based on findings in animals and mechanism of action, Orgovyx can cause fetal harm and loss of pregnancy when administered to a pregnant female. There are no human data on the use of Orgovyx in pregnant females to inform the drug-associated risk. In an animal reproduction study, oral administration of relugolix to pregnant rabbits during organogenesis caused embryo-fetal lethality at maternal exposures that were 0.3 times the human exposure at the recommended dose of 120 mg daily based on AUC. Advise patients of the potential risk to the fetus.

Lactation

Risk Summary

The safety and efficacy of Orgovyx at the recommended dose of 120 mg daily have not been established in females. There are no data on the presence of relugolix in human milk, the effects on the breastfed child, or the effects on milk production. Relugolix and/or its metabolites were present in milk of lactating rats.

Females and Males of Reproductive Potential

Contraception

Males

Based on findings in animals and mechanism of action, advise male patients with female partners of reproductive potential to use effective contraception during treatment and for 2 weeks after the last dose of Orgovyx.

Infertility

Males

Based on findings in animals and mechanism of action, Orgovyx may impair fertility in males of reproductive potential.

Pediatric Use

The safety and efficacy of Orgovyx in pediatric patients have not been established.

Geriatric Use

Of the 622 patients who received Orgovyx in the HERO study, 81% were 65 years of age or older, while 35% were 75 years of age or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects. There was no clinically relevant impact of age on the pharmacokinetics of Orgovyx or testosterone response based on population pharmacokinetic and pharmacokinetic/pharmacodynamic analyses in men 45 to 91 years of age.

CLINICAL STUDIES

HERO Study

The safety and efficacy of Orgovyx was evaluated in HERO (NCT03085095), a randomized, open label study in men with advanced prostate cancer requiring at least 1 year of androgen deprivation therapy and defined as biochemical (PSA) or clinical relapse following local primary intervention, newly diagnosed castration-sensitive metastatic disease, or advanced localized disease.

A total of 934 patients were randomized to receive Orgovyx or leuprolide in a 2:1 ratio for 48 weeks:

- Orgovyx at a loading dose of 360 mg on the first day followed by daily doses of 120 mg orally
- Leuprolide acetate 22.5 mg injection (or 11.25 mg in Japan and Taiwan) subcutaneously every 3 months. Leuprolide acetate 11.25 mg is a dosage regimen that is not recommended for this indication in the US.

Serum testosterone concentrations were measured at screening; on Days 1, 4, 8, 15, and 29 in the first month; then monthly until the end of the study.

The population (N = 930) across both treatment groups had a median age of 71 years (range 47 to 97 years). The ethnic/racial distribution was 68% White, 21% Asian, 4.9% Black, and 5% other. Disease stage was distributed as follows: 32% metastatic (M1), 31% locally advanced (T3/4 NX M0 or any T N1 M0), 28% localized (T1 or T2 N0 M0), and 10% not classifiable. The median testosterone concentration at baseline across the treatment groups was 408 ng/dL.

The major efficacy outcome measure was medical castration rate defined as achieving and maintaining serum testosterone suppression to castrate levels (< 50 ng/dL) by Day 29 through 48 weeks of treatment. Other endpoints included castration rates on Day 4 and 15 and castration rates with testosterone < 20 ng/dL at Day 15.



The efficacy results are shown in Table 1 and the time course of percent change from baseline in testosterone suppression by Orgovyx and leuprolide

during the 48-week treatment period are shown in Figure 1.

The percentages of patients who attained the medical castration levels of

testosterone < 50 ng/dL and < 20 ng/dL within the first 29 days of treatment are summarized in Table 2.

In the clinical trial, PSA levels were monitored and were lowered on average by 65% 2 weeks after administration of Orgovyx, 83% after 4 weeks, 92% after 3 months and remained suppressed throughout the 48 weeks of treatment. These PSA results should be interpreted with caution because of the heterogeneity of the patient population studied. No evidence has shown that the rapidity of PSA decline is related to a clinical benefit.

A substudy was conducted in 137 patients who did not receive subsequent androgen deprivation therapy for at least 90 days after discontinuation of Orgovyx. Based on Kaplan-Meier analyses, 55% of patients achieved testosterone levels above the lower limit of the normal range (> 280 ng/dL) or baseline at 90 days after discontinuation of Orgovyx.

HOW SUPPLIED/STORAGE AND HANDLING

The 120 mg tablets are film-coated, light red, almond shaped, and debossed with “R” on one side and “120” on the other side and are supplied in two configurations, bottles and blister packs. Each bottle (NDC 72974-120-01) contains 30 tablets and a desiccant and is closed with a child-resistant induction seal cap. The blister cards contain nine tablets packaged in a carton (NDC 72974-120-02). Each Orgovyx tablet contains 120 mg of relugolix.

- Store Orgovyx at room temperature. Do not store above 30°C (86°F).
- Dispense to patients in original container only.
- For bottles, keep container tightly closed after first opening.

For full prescribing information, please see product insert.

Orgovyx is manufactured by Bushu Pharmaceuticals, Ltd. for Myovant Sciences.

TABLE 1 MEDICAL CASTRATION RATES (TESTOSTERONE CONCENTRATIONS < 50 NG/DL) FROM DAY 29 THROUGH WEEK 48 IN HERO

| | Orgovyx 360/120 mg (N = 622)^b | Leuprolide acetate 22.5 or 11.25 mg^a (N = 308)^b |
|---|---|--|
| Castration rate (95% CI)^c | 96.7% 94.9%, 97.9% | 88.8% (84.6%, 91.8%) |

- a. 11.25 mg is a dosage regimen that is not recommended for this indication in the US. The castration rate of the subgroup of patients receiving 22.5 mg leuprolide (n = 264) was 88.0% (95% CI: 83.4%, 91.4%).
- b. Two patients in each arm did not receive the study treatment and were not included.
- c. Kaplan-Meier estimates within group.

FIGURE 1 MEAN (95% CI) PERCENT CHANGE FROM BASELINE IN TESTOSTERONE CONCENTRATIONS FROM BASELINE TO WEEK 49 BY TREATMENT GROUP IN HERO

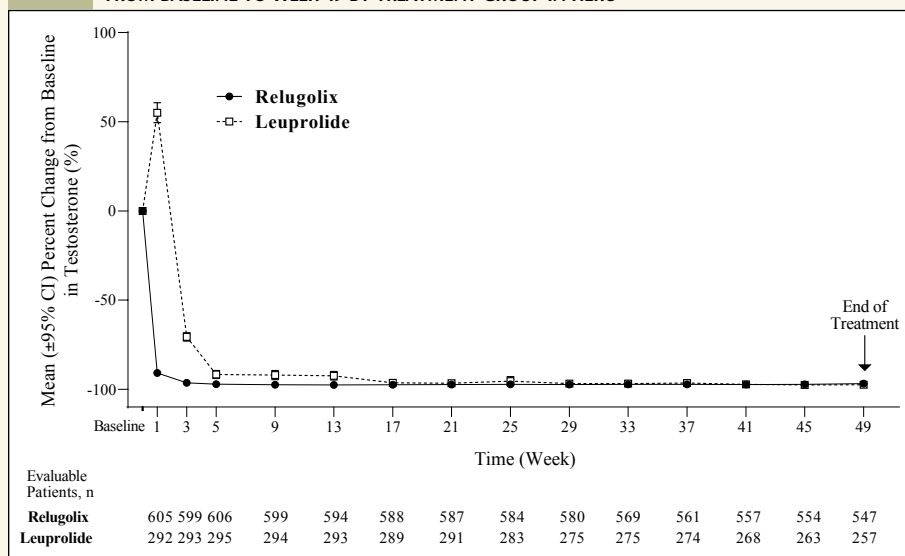


TABLE 2 PERCENTAGE OF PATIENTS ATTAINING TESTOSTERONE DECREASES WITHIN THE FIRST 29 DAYS IN HERO^a

| | Testosterone < 50 ng/dL | | Testosterone < 20 ng/dL | |
|---------------|------------------------------|---|------------------------------|---|
| | Orgovyx (N = 622) | Leuprolide acetate (N = 308) | Orgovyx (N = 622) | Leuprolide acetate (N = 308) |
| Day 4 | 56% | 0% | 7% | 0% |
| Day 8 | 91% | 0% | 27% | 0% |
| Day 15 | 99% | 12% | 78% | 1% |
| Day 29 | 99% | 82% | 95% | 57% |

- a. Kaplan-Meier estimates within group.



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

AIDS Res Hum Retroviruses. 2021 Feb 25.

[Sex differences in the association between stress, loneliness, and COVID-19 burden among people with HIV in the US](#)

Jones DL, Rodrigues VJ, Salazar AS, et al.

BACKGROUND: Little is known about the psychological implications of the COVID-19 pandemic on people with HIV (PWH). The purpose of this study was to assess the impact of COVID-19 among men and women with HIV in Miami FL, USA. We hypothesized that the burden of the COVID-19 pandemic will be higher for women, and psychological factors will increase COVID-19 burden among them.

METHODS: People with (n = 231) and without HIV (n = 42) residing in Miami, FL completed a survey assessing psychological outcomes such as loneliness, depression and stress, as well as the burden of COVID-19 on their daily lives. T-tests and Chi-square analyses were used to assess sex differences in study variables. Logistic regression was used to compare the interaction effects predicting stress and loneliness by COVID-19 burden and sex.

RESULTS: A total of 273 completed the survey; the outcomes of the study, loneliness and stress, did not differ by HIV status (p = .458 and p = 922). Overall, men and women reported similar prevalence of COVID-19 burden. However, a greater proportion of women reported losing childcare than men (18% vs 9%, p = 0.029, respectively), as well as losing mental health care (15% vs 7%, p = 0.049). There was a significant interaction between COVID-19 burden and sex for loneliness and stress such that the association between COVID-19 burden and loneliness was greater for women (p<0.001) than for men (p = 0.353) and the association between COVID-19 burden and stress was greater for women (p = 0.013) than men (p = 0.628).

CONCLUSIONS: Both men and women with HIV are impacted by the COVID-19 pandemic, but women may experience higher levels of stress and loneliness than men. Sex differences may require tailored interventions to more effectively mitigate the impact of the pandemic on mental health.

Clin Infect Dis. 2021 Feb 20;ciab154. doi: 10.1093/cid/ciab154. Online ahead of print.

[Characteristics and factors associated with COVID-19 infection, hospitalization, and mortality across race and ethnicity](#)

Dai CL, Kornilov SA, Roper RT, et al.

BACKGROUND: Data on the characteristics of COVID-19 patients disaggregated by race/ethnicity remain limited. We evaluated the sociodemographic and clinical characteristics of patients across racial/ethnic groups and assessed their associations with COVID-19 outcomes.

METHODS: This retrospective cohort study examined 629,953 patients tested for SARS-CoV-2 in a large health system spanning California, Oregon, and Washington between March 1 and December 31, 2020. Sociodemographic and clinical characteristics were obtained from electronic health records. Odds of SARS-CoV-2 infection, COVID-19 hospitalization, and in-hospital death were assessed with multivariate logistic regression.

RESULTS: 570,298 patients with known race/ethnicity were tested for SARS-CoV-2, of whom 27.8% were non-White minorities. 54,645 individuals tested positive, with minorities representing 50.1%. Hispanics represented 34.3% of infections but only 13.4% of tests. While generally younger than White patients, Hispanics had higher rates of diabetes but fewer other comorbidities. 8,536 patients were hospitalized and 1,246 died, of whom 56.1% and 54.4% were non-White, respectively. Racial/ethnic distributions of outcomes across the health system tracked with state-level statistics. Increased odds of testing positive and hospitalization were associated with all minority races/ethnicities. Hispanic patients also exhibited increased morbidity, and Hispanic race/ethnicity was associated with in-hospital mortality (OR: 1.39 [95% CI: 1.14-1.70]).

CONCLUSION: Major healthcare disparities were evident, especially among Hispanics who tested positive at a higher rate, required excess hospitalization and mechanical ventilation, and had higher odds of in-hospital mortality despite younger age. Targeted, culturally-responsive interventions and equitable vaccine development and distribution are needed to address the increased risk of poorer COVID-19 outcomes among minority populations.

Clin Infect Dis. 2021 Feb 23;ciab169. doi: 10.1093/cid/ciab169. Online ahead of print.

[Accelerated brain aging and cerebral blood flow reduction in persons with HIV](#)

Petersen KJ, Metcalf N, Cooley S, et al.

BACKGROUND: Persons with HIV (PWH) are characterized by altered brain structure and function. As they attain normal lifespans, it has become crucial to understand potential interactions between HIV and aging. However, it remains unclear how brain aging varies with viral load (VL).

METHODS: In this study, we compare MRI biomarkers amongst PWH with undetectable VL (UVL; ≤ 50 genomic copies/ml; $n=230$), PWH with detectable VL (DVL; >50 copies/ml; $n=93$), and HIV uninfected (HIV-) controls ($n=206$). To quantify gray matter cerebral blood flow (CBF), we utilized arterial spin labeling. To measure structural aging, we used a publicly available deep learning algorithm to estimate brain age from T1-weighted MRI. Cognitive performance was measured using a neuropsychological battery covering five domains.

RESULTS: Associations between age and CBF varied with VL. Older PWH with DVL had reduced CBF vs. PWH with UVL ($p=0.02$). Structurally predicted brain aging was accelerated in PWH vs. HIV- controls regardless of VL ($p<0.001$). Overall, PWH had impaired learning, executive function, psychomotor speed, and language compared to HIV- controls. Structural brain aging was associated with reduced psychomotor speed ($p<0.001$).

CONCLUSIONS: Brain aging in HIV is multifaceted. CBF depends on age and current VL, and is improved by medication adherence. By contrast, structural aging is an indicator of cognitive function and reflects serostatus rather than current VL.

Int J Infect Dis. 2021 Feb 17;S1201-9712(21)00143-0. doi: 10.1016/j.ijid.2021.02.057. Online ahead of print.

[Tocilizumab treatment in critically ill patients with COVID-19: a retrospective observational study](#)

Huang E, Isonaka S, Yang H, et al.

OBJECTIVE: Elevated levels of pro-inflammatory cytokines are observed in severe COVID-19 infections and cytokine storm is associated with disease severity. Tocilizumab, an interleukin-6 receptor antagonist, is used to treat chimeric antigen receptor T cell-induced cytokine release syndrome and may attenuate the dysregulated immune response in COVID-19. We compared outcomes among tocilizumab-treated and untreated critically ill COVID-19 patients.

DESIGN, SETTING, AND PARTICIPANTS: This was a retrospective observational study conducted at a tertiary referral center investigating all patients admitted to the intensive care unit for COVID-19 who had a disposition from the hospital because of

death or hospital discharge between March 1, 2020 and May 18, 2020 ($n=96$). The percentages of death and secondary infections were compared between patients treated with tocilizumab ($n=55$) and those who were not ($n=41$).

MEASUREMENTS AND MAIN RESULTS: More tocilizumab-treated patients required mechanical ventilation (44/55, 80%) compared to non-treated patients (15/41, 37%; $p<0.001$). Of 55 patients treated with tocilizumab, 32 (58%) were on mechanical ventilation at the time of administration and 12 (22%) progressed to mechanical ventilation after treatment. Thirty of 44 (68%) treated ventilated patients were intubated within one day of tocilizumab. Fewer deaths were observed among tocilizumab-treated patients, both in the overall population (15% vs. 37%; $p=0.02$) and among the subgroup of patients requiring mechanical ventilation (14% vs. 60%; $p=0.001$). Secondary infections were not different between the two groups (tocilizumab: 31%, non-tocilizumab: 17%; $p=0.16$) and were predominantly related to invasive devices, such as urinary and central venous catheters.

CONCLUSIONS: Tocilizumab treatment was associated with fewer deaths compared to non-treatment despite predominantly being used in patients with more advanced respiratory disease.

JAMA. 2021 Feb 24. doi: 10.1001/jama.2021.2091. Online ahead of print.

[Characteristics and outcomes of US children and adolescents with multisystem inflammatory syndrome in children \(MIS-C\) compared with severe acute COVID-19](#)

Feldstein LR, Tenforde MW, Friedman KG, et al.

IMPORTANCE: Refinement of criteria for multisystem inflammatory syndrome in children (MIS-C) may inform efforts to improve health outcomes.

OBJECTIVE: To compare clinical characteristics and outcomes of children and adolescents with MIS-C vs those with severe coronavirus disease 2019 (COVID-19). Setting, design, and participants: Case series of 1116 patients aged younger than 21 years hospitalized between March 15 and October 31, 2020, at 66 US hospitals in 31 states. Final date of follow-up was January 5, 2021. Patients with MIS-C had fever, inflammation, multisystem involvement, and positive severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) reverse transcriptase-polymerase chain reaction (RT-PCR) or antibody test results or recent exposure with no alternate diagnosis. Patients with COVID-19 had positive RT-PCR test results and severe organ system involvement. Exposure: SARS-CoV-2.

MAIN OUTCOMES AND MEASURES: Presenting symptoms, organ system complications, laboratory biomarkers, interventions, and clinical outcomes. Multivariable regression was

used to compute adjusted risk ratios (aRRs) of factors associated with MIS-C vs COVID-19.

RESULTS: Of 1116 patients (median age, 9.7 years; 45% female), 539 (48%) were diagnosed with MIS-C and 577 (52%) with COVID-19. Compared with patients with COVID-19, patients with MIS-C were more likely to be 6 to 12 years old (40.8% vs 19.4%; absolute risk difference [RD], 21.4% [95% CI, 16.1%-26.7%]; aRR, 1.51 [95% CI, 1.33-1.72] vs 0-5 years) and non-Hispanic Black (32.3% vs 21.5%; RD, 10.8% [95% CI, 5.6%-16.0%]; aRR, 1.43 [95% CI, 1.17-1.76] vs White). Compared with patients with COVID-19, patients with MIS-C were more likely to have cardiorespiratory involvement (56.0% vs 8.8%; RD, 47.2% [95% CI, 42.4%-52.0%]; aRR, 2.99 [95% CI, 2.55-3.50] vs respiratory involvement), cardiovascular without respiratory involvement (10.6% vs 2.9%; RD, 7.7% [95% CI, 4.7%-10.6%]; aRR, 2.49 [95% CI, 2.05-3.02] vs respiratory involvement), and mucocutaneous without cardiorespiratory involvement (7.1% vs 2.3%; RD, 4.8% [95% CI, 2.3%-7.3%]; aRR, 2.29 [95% CI, 1.84-2.85] vs respiratory involvement). Patients with MIS-C had higher neutrophil to lymphocyte ratio (median, 6.4 vs 2.7, $P < .001$), higher C-reactive protein level (median, 152 mg/L vs 33 mg/L; $P < .001$), and lower platelet count ($<150 \times 10^3$ cells/ μ L [212/523 {41%}] vs 84/486 {17%}, $P < .001$). A total of 398 patients (73.8%) with MIS-C and 253 (43.8%) with COVID-19 were admitted to the intensive care unit, and 10 (1.9%) with MIS-C and 8 (1.4%) with COVID-19 died during hospitalization. Among patients with MIS-C with reduced left ventricular systolic function (172/503, 34.2%) and coronary artery aneurysm (57/424, 13.4%), an estimated 91.0% (95% CI, 86.0%-94.7%) and 79.1% (95% CI, 67.1%-89.1%), respectively, normalized within 30 days.

CONCLUSIONS AND RELEVANCE: This case series of patients with MIS-C and with COVID-19 identified patterns of clinical presentation and organ system involvement. These patterns may help differentiate between MIS-C and COVID-19.

Am J Cardiol. 2021 Feb 19;S0002-9149(21)00145-4. doi: 10.1016/j.amjcard.2021.01.036. Online ahead of print.

[Economic evaluation of an n-terminal pro B-type natriuretic peptide-supported diagnostic strategy among dyspneic patients suspected of acute heart failure in the emergency department](#)

Siebert U, Miley S, Zou D, et al.

Our objective was to perform an economic evaluation of an N-terminal pro B-type natriuretic peptide (NT-proBNP)-supported diagnostic strategy among dyspneic patients suspected of acute heart failure (AHF) in the emergency department (ED). A decision-tree model was developed to evaluate clinical outcomes and costs for

NT-proBNP-supported assessment compared with clinical assessment alone over 6 months from the United States (US) Medicare perspective. The model considered rule-in/rule-out cutoffs identified in the ICON and ICON-RELOADED studies. AHF prevalence, diagnostic accuracies, and medical resource use conditional on disease status and test results were derived from ICON-RELOADED. Several assumptions based on prior studies of NT-proBNP acute dyspnea and verified with clinicians were applied to medical resource use and assessed in sensitivity analyses. Compared with clinical assessment alone, NT-proBNP-supported assessment improved overall probability of correct diagnosis by a relative 7% (18% for true-positive and 5% for true-negative). This led to relative reductions in medical resource use in ED and hospital, including fewer initial hospitalizations (-14%), required echocardiograms (-31%), cardiology admissions (-16%), intensive care unit admissions (-12%), ED readmissions (-3%), and hospital readmissions (-22%). NT-proBNP use decreased average inpatient management costs by a relative 10%, yielding cost savings of US\$2,337 per patient ED visit. These findings were robust in sensitivity analyses. In conclusion, based on a contemporary trial of patients with acute dyspnea, this analysis reaffirmed that using NT-proBNP as a diagnostic tool may improve the management of patients with dyspnea presenting to EDs and is likely to be cost-saving from the US Medicare perspective.

JAMA. 2021 Feb 26. doi: 10.1001/jama.2021.2747.

Online ahead of print.

[Association of convalescent plasma treatment with clinical outcomes in patients with COVID-19: a systematic review and meta-analysis](#)

Janiaud P, Axfors C, Schmitt AM, et al.

IMPORTANCE: Convalescent plasma is a proposed treatment for COVID-19. **Objective:** To assess clinical outcomes with convalescent plasma treatment vs placebo or standard of care in peer-reviewed and preprint publications or press releases of randomized clinical trials (RCTs).

DATA SOURCES: PubMed, the Cochrane COVID-19 trial registry, and the Living Overview of Evidence platform were searched until January 29, 2021.

STUDY SELECTION: The RCTs selected compared any type of convalescent plasma vs placebo or standard of care for patients with confirmed or suspected COVID-19 in any treatment setting. **Data extraction and synthesis:** Two reviewers independently extracted data on relevant clinical outcomes, trial characteristics, and patient characteristics and used the Cochrane Risk of Bias Assessment Tool. The primary analysis included peer-reviewed publications of RCTs only, whereas the secondary analysis included all publicly available RCT data (peer-reviewed publications, preprints,

and press releases). Inverse variance-weighted meta-analyses were conducted to summarize the treatment effects. The certainty of the evidence was assessed using the Grading of Recommendations Assessment, Development, and Evaluation. Main outcomes and measures: All-cause mortality, length of hospital stay, clinical improvement, clinical deterioration, mechanical ventilation use, and serious adverse events.

RESULTS: A total of 1060 patients from 4 peer-reviewed RCTs and 10 722 patients from 6 other publicly available RCTs were included. The summary risk ratio (RR) for all-cause mortality with convalescent plasma in the 4 peer-reviewed RCTs was 0.93 (95% CI, 0.63 to 1.38), the absolute risk difference was -1.21% (95% CI, -5.29% to 2.88%), and there was low certainty of the evidence due to imprecision. Across all 10 RCTs, the summary RR was 1.02 (95% CI, 0.92 to 1.12) and there was moderate certainty of the evidence due to inclusion of unpublished data. Among the peer-reviewed RCTs, the summary hazard ratio was 1.17 (95% CI, 0.07 to 20.34) for length of hospital stay, the summary RR was 0.76 (95% CI, 0.20 to 2.87) for mechanical ventilation use (the absolute risk difference for mechanical ventilation use was -2.56% [95% CI, -13.16% to 8.05%]), and there was low certainty of the evidence due to imprecision for both outcomes. Limited data on clinical improvement, clinical deterioration, and serious adverse events showed no significant differences.

CONCLUSIONS AND RELEVANCE: Treatment with convalescent plasma compared with placebo or standard of care was not significantly associated with a decrease in all-cause mortality or with any benefit for other clinical outcomes. The certainty of the evidence was low to moderate for all-cause mortality and low for other outcomes.

Eur J Heart Fail. 2021 Feb 26. doi: 10.1002/ehf.2142. Online ahead of print.

[Diagnostic scores predict morbidity and mortality in patients hospitalised for heart failure with preserved ejection fraction](#)

Verbrugge FH, Reddy YNV, Sorimachi H, et al.

AIMS: To investigate the prognostic value of diagnostic scores for heart failure with preserved ejection fraction (HFpEF).

METHODS AND RESULTS: Consecutive patients with HFpEF admitted for unequivocal decompensated HF treated with intravenous loop diuretics were evaluated (n=443; 78±12 years; 60% women). The HFA-PEFF and H2 FPEF scores were calculated for all patients with echocardiography data available within 1 year and the population was stratified according to HFA-PEFF scores 2-4 (n=79), 5 (n=93), or 6 (n=271) and H2 FPEF score probabilities <90% (n=80), 90-95% (n=61), and 96-100% (n=293).

HF readmission rates (95% confidence intervals) increased from 28.9 (22.7-35.0) per 100 patient-years in HFA-PEFF 2-4 to 46.0 (38.5-53.5) in HFA-PEFF 5 and 45.0 (40.1-49.8) in HFA-PEFF 6. Similarly, HF readmission rates increased with increasing H2 FPEF probability: <0.90 [31.8 (25.3-38.2) per 100 patient-years], 0.90-0.95 [41.5 (32.9-50.1)], and 0.96-1.00 [45.9 (41.2-50.6)]. Median survival was 65 months (36-89 months) in HFA-PEFF score 2-4, 45 months (26-59 months) in HFA-PEFF score 5, and 28 months (22-42 months) in HFA-PEFF score 6 (P-value<0.001), while the hazard ratio (95% confidence interval) for all-cause mortality was 1.16 (1.02-1.32) per 0.10 increase in H2 FPEF probability.

CONCLUSIONS: Among patients hospitalized with HFpEF, higher HFpEF probability according to diagnostic scores is associated with increased risk of subsequent HF readmissions and all-cause mortality.

Am Heart J. 2021 Feb 20;S0002-8703(21)00055-7. doi: 10.1016/j.ahj.2021.02.016. Online ahead of print.

[Cardiac transplantation outcomes in patients with amyloid cardiomyopathy](#)

Ohiomoba R, Youmans O, Ezema A, et al.

OBJECTIVE: Amyloid cardiomyopathy (ACM) is a progressive and life-threatening disease caused by abnormal protein deposits within cardiac tissue. The most common forms of ACM are caused by immunoglobulin derived light chains (AL) and transthyretin (TTR). Orthotopic Heart Transplantation (OHT) remains the definitive treatment for patients with end stage heart failure. In this study, we perform a contemporary multi-center analysis evaluating post OHT survival in patients with ACM.

METHODS: We conducted a multi-center analysis of 40,044 adult OHT recipients captured in the United Network for Organ Sharing (UNOS) registry from 1987-2018. Patients were characterized as ACM or Non-ACM. Baseline characteristics were obtained, and summary characteristics were calculated. Outcomes of interest included post-transplant survival, infection, treated rejection, and the ability to return to work. Racial differences in OHT survival were also analyzed. Unadjusted associations between ACM and non-ACM survival were determined using the Kaplan-Meier estimations and confounding was addressed using multivariable Cox proportional hazards models.

RESULTS: 398 patients with a diagnosis of ACM were identified of which 313 underwent heart only OHT. ACM patients were older (61 vs 53; p<0.0001) and had a higher proportion of African Americans (30.7% vs 17.6%; p<0.0001). Median survival for ACM was 10.2 years vs 12.5 years in Non-ACM (p=0.01). After adjusting for confounding, ACM patients had a higher likelihood

of death post-OHT (HR 1.39 (CI:1.14,1.70; p= 0.001). African American ACM patients had a higher likelihood of survival compared to White ACM patients (HR 0.51 (CI 0.31-0.85; p=0.01). No difference was observed in episodes of treated rejection (OR 0.63 (CI 0.23, 1.78; p=0.39), hospitalizations for infections (OR 1.24 (CI: 0.85, 1.81; p=0.26), or likelihood of returning to work for income (OR 1.23 (CI: 0.84, 1.80; p=0.30).

CONCLUSION: In this analysis of OHT in ACM, ACM was associated with a higher likelihood of post-OHT mortality. Racial differences in post-OHT were observed with African American patients with ACM having higher likelihood of survival compared to White patients with ACM. No differences were observed in episodes of treated rejection, hospitalization for infection, or likelihood to return to work for income.

Clin Transplant. 2021 Feb;35(2):e14183. doi: 10.1111/ctr.14183. Epub 2020 Dec 19.

[Designing a patient-specific search of transplant program performance and outcomes: feedback from heart transplant candidates and recipients](#)

McKinney WT, Schaffhausen CR, Schladt D, et al.

BACKGROUND: The Scientific Registry of Transplant Recipients provides transplant program-specific information, but it is unclear what patients and stakeholders need to know. Acceptance criteria for the candidate waitlist and donor organs vary by program and region, but there is no means to search for programs by the clinical profiles of recipients and donors.

METHODS: We examined variability in program-specific characteristics that could influence access to transplantation. We also conducted three interviews and three focus groups with heart transplant candidates and recipients. Participants evaluated prototypes of a patient-specific search tool and its capacity to identify programs tailored to specific patient needs. Patient experiences and feedback influenced the development of tools.

RESULTS: The distribution of recipient and donor characteristics influenced access to transplantation, as age and body mass index varied across programs (all with p < .01). Several themes emerged related to decision-making and the perceived usability of the patient-specific search. Perceptions of the prototypes varied, but were positive overall and support making the patient-specific search publicly available. Participants revealed barriers to evaluating transplant programs and suggest that patient-specific search results may optimize the process.

CONCLUSIONS: The patient-specific tool (<http://transplantcentersearch.org/>) is valued by heart transplant patients and is important to maximizing access to transplant. ■

[continued from page 16](#)

Martin, S. (2018). The effects of growing up in a dysfunctional family. Retrieved 12/12/20 from: <https://sharonmartincounseling.com/the-effects-of-growing-up-in-a-dysfunctional-family/>

McDonald, G., O'Brian, L. & Jackson, D. (2007). Guilt and shame: Experiences of parents of self-harming adolescents. *Journal of Child Health Care* 11(4), 298-310.

McLeod, S. (2018). Mary Ainsworth. Simply Psychology. Retrieved 11/11/20 from: <https://www.Simplepsychology.org/maryainsworth.html>.

Newberg, A.B. (2014). The neuroscientific study of religious practices. *Frontiers in Psychology* 5:213, 1-8.

Payne, I.R., Bergin, A.E., Bielema, K.A. & Jenkins, P.H. (2008). Review of religion and mental health. *International Review of Psychiatry* 13(2), 11-40.

Rapp, C.A., Saleebey, D., & Sullivan, W.P. (2005). The future of strengths-based social work. *Advances in Social Work* 6(1), 79-90.

Riggs, S.A. (2010). Childhood emotional abuse and the attachment system across the life cycle: What theory and research tell us. *Journal of Aggression, Maltreatment & Trauma* 19(1).

Salters-Pedneault (2019, p.1). What are shame and guilt? How are they different? Retrieved 11/24/20 from: <https://www.verywellmind.com/Disorders>BPD>Living with BPD>

Sword, R.K.M. & Zimbardo, P. (2018). Remorse. Psychology Today. Retrieved 11/7/20 from: <https://www.psychologytoday.com/blog/the-time-cure/remorse>

Van Wormer, K. (2003). Restorative justice: A model for social work practice with families. *Families in Society; The Journal of Contemporary Human Services*. 84(3), 441-448.

Wachtel, T. (2019). Defining Restorative. What We Do. IIRP Graduate School. Retrieved from: <https://www.iirp.edu/What We Do/What is Restorative Processes?>


Whitbourne, S.K. (2012). The definitive guide to guilt. Retrieved 11/20/20 from: <https://www.psychologytoday.com/us/blog/fulfillment-any-age/201208/the-definitive-guide-guilt>

Yelsma, P., Brown, N.M. & Elison, J. (2002). Shame-focused coping styles and their associations with self-esteem. *Psychological Reports* 90, 1179-1189.

Providing Case Management Telehealth—Am I Ready?

[continued from page 12](#)

- Encompass settings such as:
 - Hospitals, clinics, professional offices, and other organization-based settings.
 - Schools, work sites, libraries, community centers, and other community setting,
 - Congregate living, individual homes, and other residential settings.

If you are interested in learning more about the standards for ICT, please contact Chris MacDonell at cmacdonell@carf.org. 

Raising the Bar on Continuing Education for Case Managers

[continued from page 9](#)

of CEs.

The Symposium is one example of the evolution of continuing education—largely due to necessity but also in response to participants' changing needs. Going forward, immediately postpandemic, there will likely be a hunger for in-person learning and networking experiences when such events can be convened safely. At the same time, the ease, access, and cost-effectiveness of virtual training will likely continue to make it appealing. In fact, over time, case managers can be expected to pursue hybrid experiences, with some training and professional development delivered in person and other learning accessed virtually.

Case managers, as well as those in allied professions, will become informed consumers of education, whether it is delivered virtually, in person, or a hybrid of both. The

discernment will consider not only cost, but also time away from one's job. In the future, instead of taking vacation days for in-person continuing education, case managers may opt to devote that time off to leisure travel. It is a reality that cannot be overlooked by continuing education providers.

While such changes will alter how and where continuing education occurs, the demand for quality content is paramount. Whether learning occurs virtually, in person, or as a hybrid experience, the bar is being raised with expectations for excellence in content and delivery to make learning truly enriching. **CM**

How to Connect with Patients

[continued from page 5](#)

patients' verbal and nonverbal emotional cues, such as changes in patients' tone of voice, facial expressions, and body language. Practitioners should also elicit expressions of emotion from patients through questions such as, "How are you feeling about this?" Reflecting and validating perceptions of patients' emotions is also important.

Although emphasis on compliance with a myriad of regulatory requirements is certainly justified, the focus must remain on patients and encounters with them. In addition, effective interactions with patients may be the best way to ensure quality of care and manage risks. **CM**

©2021 Elizabeth E. Hogue, Esq.

All rights reserved.

No portion of this material may be reproduced in any form without the advance written permission of the author.

Case Management for the Seriously Ill and Injured Sailor and Marine

[continued from page 10](#)

recovery plan (CRP) is developed by the case management team with the service member to address a multitude of matters that are listed on a checklist. Matters such as financial needs are on this list to check if the service member may need unemployment compensation or file a Veteran's Compensation and Pension claim. Legal needs are also assessed such as potential need for guardianship or power of attorney. A review of military awards and promotions is conducted. Spirituality, career counseling, assistance for activities of daily living, and family support as well as health and financial needs are

all thoroughly assessed and included. The RSM and family or designated caregiver and the RCC review the CRP and sign the document to demonstrate their understanding of the plan and commitment to its implementation.

The Wounded Warrior program for the U.S. Marine Corps is known as the Wounded Warrior Regiment (woundedwarrior.marines.mil/). The Navy's program is the Navy Wounded Warrior program and provides nonmedical services to both the Navy and Coast Guard (navywoundedwarrior.com/).

The Navy Medical case managers are largely located at the hospitals and clinics of MTFs. Each of the MTFs have a website under the name of the MTF with a TRICARE link called, "Learn About Case Management." By accessing

that internet link, information is provided on how to reach a case manager for patients, civilians, or military personnel who are looking for MHS MTF case management help.

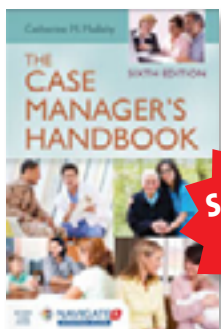
When active duty service members are admitted to a civilian facility, the MHS case managers are notified of the admission through the MCSC hospital admission notification systems. The MCSC will authorize the active duty service member's admission, and the MHS case managers will work with the civilian facilities to return the service members back to the MHS MTF when safe, as soon as reasonable, and when the MTF has the capability and capacity for care. This is all done to meet the readiness mission of the MHS. **CM**



Case Managers: There's no better time to advance your career than now!

Whether you're an experienced Certified Case Manager (CCM), a new case manager looking to earn your CCM credential, or a case manager thinking about starting your own case management practice, Catherine M. Mullahy, RN, BS, CRRN, CCM and Jeanne Boling, MSN, CRRN, CDMS, CCM can help. Their award-winning case management education and training resources incorporate their decades of experience, leadership and success in case management. These CMSA Lifetime Achievement Award Winners and veterans who helped develop case management standards and codes of conducts have created "Best in Class" tools to address your career needs and goals.

Here are just some of Mullahy & Associates' career-advancing resources:



Save 20%
with code
20ACCM

THE CASE MANAGER'S HANDBOOK, 6TH EDITION

- The definitive resource in case management
- A trusted study guide for CCM preparation
- A comprehensive compendium of best practice fundamentals, latest developments, strategies for managing various cases, legal and ethical issues, and much more
- Used in nursing schools/university curriculum across the globe

ORDER NOW!



Save 25%
with code
25ACCM

BEST IN CLASS CASE MANAGEMENT ONLINE COURSE, 2.0 EDITION

- Your gateway to certification and leading-edge practice
- 14 Interactive, Multi-Media Modules which together define case management and the duties of a case manager
- Ideal for beginners, intermediate and advanced level learners
- Aligned with the CCMC Knowledge Domains
- Study at your own pace, 24/7, with easy to access online content
- Robust platform complete with sample questions, helpful study tips, case management videos and more

ORDER NOW!



Save 25%
with code
25GEPCM

GOLD ENTREPRENEUR PACKAGE FOR INDEPENDENT CASE MANAGERS

- Designed to help you build a successful case management business
- Includes marketing brochures, administrative & practice management tools, templates and access to an online forms library
- Complete with a copy of The Case Manager's Handbook, Sixth Edition and Direct-to-Consumer Case Management Guide provided
- Provides mentoring access with experienced industry leaders

ORDER NOW!

To learn more about these career-advancing resources and others [click here](#), or call: 631-673-0406.



Seasons! [continued from page 7](#)

respond to changing priorities CMSA is providing webinars, courses, and roundtables on topics that affect case managers in today's environment. These topics range from leadership, mentorship, and clinical practice to COVID care management, vaccine hesitancy, and health disparities. We have improved the technology that supports our communication systems to streamline our ability to connect with members and nonmembers. CMSA celebrates our legacy and new partners within the industry, and we are excited about our joint efforts to advance the profession of case management. The multidisciplinary embrace of case managers from across the industry will ensure that patients who need the most complex care management have the breadth and depth of experience from across the professional spectrum.

The season of spring is anticipatory, and the summer will yield the culmination of CMSA activities during our annual conference on June 7–10, 2021. Registration is open for CMSA's 31st Annual Conference and Expo, a high-powered mix of diverse education sessions, leading industry experts, and valuable networking opportunities (<https://cmsa.societyconference.com/v2/>). **CM**

Don't forget to check out CMSA on social media for updates on programs, activities, campaigns, and more!

Facebook: /cmsanational

Twitter: @CMSANational

LinkedIn: Search "CMSA"

On the web: www.cmsa.org

References

1. Bridges, Williams. *The Transition Model, Managing Transitions*, 1991. <https://wmbridges.com/about/what-is-transition/>
2. Kierkegaard, S. (1852). *The Rotation of Crops—A Venture in a Theory of Social Prudence*

COVID-19 Hotline: Connecting Patients to Care [continued from page 11](#)

improve their health and quality of life.

After receiving information I shared about the family's needs, Blessing Care Coordination social workers worked quickly with other organizations to obtain resources for the family. As a result, a local food pantry provided groceries and cleaning supplies. The bountiful donations were loaded into a car and delivered to the family's home. Because of the positive COVID-19 case in the household, staff unloaded the donations in family's driveway as the family watched from a window.

As staff were leaving, the dad yelled an emotional and tearful "thank you" from the window.

In addition to donations from the health department and food pantry, the Blessing Foundation paid the family's current month's rent, an Unmet Needs Program paid the family's back rent and internet (the children needed the connection for their remote learning), and the office staff of the family's pediatrician paid their utility bill.

The nurses staffing the Blessing Health System COVID-19 Hotline have answered tens of thousands of calls and questions since the pandemic began, oftentimes not knowing how much help they provided to the person on the other end of the telephone line.

Except this time.

As a registered nurse, case manager, and mother, I am proud to be able to collaborate with other experts to assist families in need. **CM**

Write for *CareManagement*

CareManagement welcomes articles that explain, illuminate, interpret, and advance case management in all practice settings. Topics include case management models and trends, care plans, business and legal aspects of case management, medical treatments and medications, case management education, outcomes measurement, developments in certification and legislation, ethical issues, advancements in managed care, and new products and equipment.

Manuscripts are accepted for publication with the understanding that they are contributed solely to *CareManagement* and are reviewed by members of *CareManagement's* peer review panel for accuracy, relevancy, and readability.

Style guidelines for manuscripts are as follows:

- Manuscript length is 3,000+ words
- Number all pages of manuscript including reference list, tables, and figure legends
- Use APA style for references

Please send manuscripts or inquiries to:

Catherine Mullahy at cmullahy@academyccm.org.

REFER A COLLEAGUE TO ACCM

Help your colleagues maintain their certification by referring them to ACCM for their continuing education needs. They can join ACCM at www.academyCCM.org/join or by mailing or faxing the Membership Application on the next page to ACCM.

Why join ACCM? Here are the answers to the most commonly asked questions about ACCM Membership:

Q: Does membership in ACCM afford me enough CE credits to maintain my CCM certification?

A: If you submit all of the CE home study programs offered in *CareManagement*, you will accumulate 90 CE credits every 5 years.

Q: Does membership in ACCM afford me enough ethics CE credits to maintain my CCM certification?

A: If you submit all of the CE home study programs for ethics credits offered in *CareManagement*, you will accumulate at least 10 ethics CE credits every 5 years.

Q: Are CE exams available online?

A: Yes, ACCM members may mail exams or take them online. When taking the exam online, you must print your certificate after successfully completing the test. *This is a members only benefit.* If mailing the exam is preferred, print the exam from the PDF of the issue, complete it, and mail to the address on the exam form.

Q: Where can I get my membership certificate?

A: Print your membership certificate instantly from the website or [click here](#). Your membership is good for 1 year based on the time you join or renew.

Q: How long does it take to process CE exams?

A: Online exams are processed instantly. Mailed exams are normally processed within 4 to 6 weeks.

Q: Do CE programs expire?

A: Continuing education programs expire in approximately 90 days. Continuing education programs that offer ethics CE credit expire in 1 year.

Q: Is your Website secure for dues payment?

A: ACCM uses the services of PayPal, the nation's premier payment processing organization. No financial information is ever transmitted to ACCM.

application on next page

join/renew ACCM online at www.academyCCM.org

HOW TO CONTACT US

CareManagement

OFFICIAL JOURNAL OF THE ACADEMY OF CERTIFIED CASE MANAGERS
AND COMMISSION FOR CASE MANAGER CERTIFICATION

Editor-in-Chief/Executive Vice President:

Gary S. Wolfe, RN, CCM, 541-505-6380
email: gwolfe@academyccm.org

Executive Editor: Catherine M. Mullahy, RN,

BS, CRRN, CCM, 631-673-0406

email: cmullahy@academyccm.org

Publisher/President: Howard Mason, RPH,

MS, 203-454-1333, ext. 1;

e-mail: hmason@academyccm.org

Art Director: Laura D. Campbell

e-mail: lcampbell@academyccm.org

Copy Editor: Esther Tazartes

e-mail: justice@dslextreme.com

Subscriptions: 203-454-1333

Website: academyCCM.org

ACCM

ACADEMY OF CERTIFIED CASE MANAGERS

Executive Vice President:

Gary S. Wolfe, RN, CCM
541-505-6380

email: gwolfe@academyccm.org

Member Services:

203-454-1333, ext. 3

e-mail: hmason@academyccm.org

Phone: 203-454-1333; fax: 203-547-7273

Website: academyCCM.org

Vol. 27, No. 2, April/May 2021.

CareManagement (ISSN #1531-037X) is published electronically six times a year, February, April, June, August, October, and December, and its contents are copyrighted by Academy of Certified Case Managers, Inc., 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990; Tel: 203-454-1333; Fax: 203-547-7273.

Do not use this application after December 31, 2021

I wish to become a member.

Date _____

First Name _____

Middle Name _____

Last Name _____

Home Address _____

City _____

State _____

Zip _____

Telephone _____

Fax _____

e-mail (required) _____

Certification ID # _____

(ACCM mailings will be sent to home address)

Practice Setting:

Which best describes your practice setting?

- Independent/Case Management Company
- Rehabilitation Facility
- Medical Group/IPA
- Hospice
- Consultant
- HMO/PPO/MCO/InsuranceCompany/TPA

- Hospital
- Home Care/Infusion
- Academic Institution
- VA
- DOD/Military
- Other: _____

JOIN ACCM TODAY!

1 year: \$120 (year begins at time of joining)

Check or money order enclosed made payable to: **Academy of Certified Case Managers.**

Mail check along with a copy of application to:

Academy of Certified Case Managers, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990.

Mastercard Visa American Express If using a credit card you may fax application to: 203-547-7273

Card # _____ Exp. Date: _____ Security Code: _____

Person's Name on Credit Card: _____ Signature: _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip: _____

join/renew ACCM online at www.academyCCM.org

For office use only: _____ Membership # _____ Membership expiration _____

HEALTH CARE CASE MANAGEMENT



**GET
CERTIFIED.**



**STAY
CERTIFIED.**



**DEVELOP
OTHERS.**

Ready to demonstrate your value?

When you become a CCM[®], you join the top tier of the nation's case managers. It's a commitment to professional excellence, elevating your career and influencing others.

The CCM is the oldest, largest and most widely recognized case manager credential.

Those three letters behind your name signal the best in health care case management.

Employers recognize proven expertise. Among employers of board-certified case managers:

- 50% require certification
- 62% help pay for the exam
- 45% help pay for recertification

Join the ranks of more than 45,000 case managers holding the **only** cross-setting, cross-discipline case manager credential for health care and related fields that's accredited by the National Commission for Certifying Agencies.

You're on your way to great things.

GET CERTIFIED. STAY CERTIFIED. DEVELOP OTHERS.

