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Gary S. Wolfe

Celebrating National Case Management Week

National Case Management Week was held October 9–15, 2022. It is time once again to celebrate and recognize case managers. This year's theme is "Setting the Standard for Patient-Centered Care." Case managers define and facilitate patient-centered care because that is what case management is all about. Case management is steeped in a rich history of being a patient advocate and helping to achieve patients' desired outcomes. Case managers know better than most about the confusion, challenges, lack of communication, and lack of coordination in health care because that is what we do. We access, plan, deliver, coordinate, educate, monitor, and evaluate to achieve our patients' desired outcomes. We accomplish our goals day after day.

This week we celebrate because we have a lot to celebrate. We have met challenge after challenge, even with new infectious diseases and natural disasters. We have changed how we work, how we gather, and how we communicate. We have designed new ways of doing case management, but we are still delivering high-quality case management services. We go out of our way to meet patients' needs in this challenging environment. We look back with pride and thankfulness because we are still meeting patients' needs. As we look forward, we will continue to meet challenges, but as case managers we are prepared to meet those challenges.

I salute all case managers. Thank you for what you do every day, frequently under difficult circumstances and in difficult situations. Congratulations! I know you will continue to do what you do and to do it well!

Celebrating National Case Management Week reminds me that case managers must take care of themselves. If you don't practice self-care, you won't be able to meet your patients' needs. It is important to take good care of your body, mind, and soul every day. Practicing self-care isn't easy. We are often too busy to practice self-care because we have stressful jobs, we have to maintain relationships, and we are consumed with technology. "Me time" is essential—sometimes you even have to schedule it. Remember that setting boundaries is a good thing.

Become a Case Management Fellow

Applications are now being accepted for the Case Management Society of America's Case Management Fellow Program. This year CMSA announced the Founding Fellows along with the Class of 2022. Being a Fellow allows you to use the designation FCM. Fellows are case managers recognized for their significant contribution to the professional practice of case management through leadership, innovation, scholarship, and contributions to the field. Fellows are leaders, mentors, ambassadors, visionaries, strategic thinkers, authors, speakers, and facilitators. It is an honor and a responsibility to be selected by your peers to be a Fellow. Applications for the Class of 2023 should be submitted now. The application process is rigorous, and the application deadline is January 9, 2023. For more information and the complete application process go to https://cmsa.org/cm-fellow/.

Hope you had a great celebration!

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ACCM: Improving Case Management Practice through Education

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Catherine M. Mullahy

The Queen's Leadership Lessons for Case Managers

If we dare to adopt the Queen's lessons of listening carefully; providing a sense of values, vision, and direction; and performing our jobs with passion, resiliency, and a clear sense of duty, we will make progress in becoming case management leaders.

With the arrival of Fall, there are several occasions to commemorate or at least recognize. We recognize and celebrate Case Management Week, which occurs from October 9–15, 2022. While the official celebration of Case Management Week will have passed when this issue is published, we hope that case managers celebrate what they do every day, not just 1 week a year.

We recently witnessed the end of the 70-year reign of a truly remarkable woman. Queen Elizabeth II has died, and even though she ascended into her position by virtue of her birth, she still needed to overcome many of the challenges that faced most women in that era. She has been widely recognized as a world leader, and we are left to wonder how she and other individuals of that generation become leaders. "One thing [the Queen] will be remembered fondly for in terms of leadership lessons is her willingness to listen," Wendy L. Patrick, a lecturer in business law at San Diego State University, said via email. "Many who worked with her described her as open-minded and forward-thinking, being receptive to hearing an opposing viewpoint and unafraid to change her mind." "The most significant leadership lesson I think we [can] take from [her is] that leaders provide a sense of values, vision, and direction for the country, organization, etc.," Andy Cohen, a professor of management at the University of Denver," said via email: "…In her approach to work, the late Queen Elizabeth embodied passion and resiliency with a clear sense of duty…" Lisa DeFrank-Cole, a director and professor of West Virginia University's leadership studies program, said via email. There is great wisdom in Queen Elizabeth's reign. If we dare to adopt the Queen's lessons of listening carefully; providing a sense of values, vision, and direction; and performing our jobs with passion, resiliency, and a clear sense of duty, we will make progress in becoming case management leaders.

Leadership shouldn't be about being aggressive or jockeying for position; it is a collaborative process where individuals always seek the best possible outcome. Some of the more desirable characteristics and leadership qualities for case managers include:

Speaking with authority and with pride and passion for your role

Educating other members of your team (eg, physicians, nurses, insurers) about your patients' needs and be willing to work toward win-win scenarios.

Keep learning; don't just think of learning as a way to obtain or maintain your professional designation but rather as a way to be a more-informed, current, and valued case manager.

Stepping outside your "comfort zone"; learning begins when you explore what you don't know!

For those of you are new to a leadership role in your organization and who might be struggling to balance your newer responsibilities, the following leadership qualities might be helpful or require a bit of "fine tuning":

Listening—know what your patients and staff understand and what you would like them to understand.

Communicate your vision including your goals. Too often staff don't understand your goals. There is a saying (attributed to Lewis Carroll in "Alice in Wonderland"): "If you don't know where you're going, any road will take you there." This is also true for some case managers who seem to be task oriented and extremely busy but never really identify goals for their intervention. The question then becomes: How do you know you're successful when you haven't identified what success is?

- Listen to patients' individual goals and help them achieve these goals
- Teach and mentor newer case managers or provide resources for them to acquire new skills
- Celebrate often when work is successful; praising folks when they are improving is a better tactic than criticism.
- Praise your team for working hard even if the desired results weren't achieved

For case managers who are seeking recognition and, perhaps,

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Enforcers Target Discharge Planners/ Case Managers Yet Again

Elizabeth Hogue, Esq.

Case managers/discharge planners continue to come under fire from fraud enforcers for violations of the federal anti-kickback statute. This statute generally prohibits anyone from either offering to give or actually giving anything to anyone in order to induce referrals. Case managers/discharge planners who violate the anti-kickback statute may be subject to criminal prosecution that could result in prison sentences, among other consequences.

Case managers/discharge planners continue to come under fire from fraud enforcers for violations of the federal anti-kickback statute. This statute generally prohibits anyone from either offering to give or actually giving anything to anyone in order to induce referrals. Case managers/discharge planners who violate the anti-kickback statute may be subject to criminal prosecution that could result in prison sentences, among other consequences.

Most recently, a U.S. District Judge in California sentenced an owner of a post-acute provider to 18 months in prison for one count of conspiracy to commit health care fraud and one count of conspiracy to pay and receive health care kickbacks. From July of 2015 through April of 2019 the provider paid and directed others to pay kickbacks to multiple case managers/discharge planners for referrals of Medicare patients, including employees of health care facilities and employees' spouses. Recipients of the kickbacks included a discharge planner/case manager at a hospital and discharge planners at skilled nursing and assisted living facilities.

Payments of kickbacks resulted in over 8,000 claims to Medicare for patients referred to the provider. Medicare paid the provider at least 2,000,000 dollars for services provided to patients referred in exchange for kickbacks. Because the provider obtained patient referrals by paying kickbacks, the provider should have not received any Medicare reimbursement. The discharge planners/case managers who received kickbacks from the provider also pled guilty and will be sentenced soon.

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS), the primary enforcer of fraud and abuse prohibitions, says that discharge planners/case managers and social workers cannot accept the following from providers who want referrals:

- Cash
- Cash equivalents, such as gift cards or gift certificates
- Non-cash items of more than nominal value
- Free discharge planning services that case managers/discharge planners and social workers are obligated to provide

Discharge planners/case managers and social workers provide extremely important services that are valued by many patients and their families, but their credibility and trustworthiness is destroyed when they make referrals based on kickbacks received.

A word to managers and all the way up the chain of command to CEOs: whether or not you know when case managers/discharge planners accept kickbacks, the OIG may also hold you responsible. You may be responsible if you knew or should have known. The OIG has made it clear that your job is to monitor and to be vigilant. A good starting point is to put in place a policy and procedure requiring discharge planners/case managers to report in writing anything received from post-acute providers. Even better, how about a policy and procedure that prohibits all gifts?

Now a word to post-acute marketers: do not give kickbacks to discharge planners/case managers and social workers. It is simply untrue that you must give kickbacks in order to get referrals. The proverbial bottom line is: Do you like the color orange? Is an orange prison uniform your preferred fashion statement? Please stop now! CM

"Painting a Picture" of the Patient for Auditors

Elizabeth Hogue, Esq.

Responding to regular audits has become an ongoing burden for many providers. Providers have repeatedly been urged to "paint a picture" of patients in clinical documentation in order to help achieve positive audit results. "Painting a picture" of the patient, however, may have become more difficult as the use of electronic health records has increased.

Audits, audits, and more audits of patient records! Responding to regular audits has become an ongoing burden for many providers. Providers have repeatedly been urged to "paint a picture" of patients in clinical documentation in order to help achieve positive audit results. "Painting a picture" of the patient, however, may have become more difficult as the use of electronic health records (EHRs) has increased. That is, it's difficult to adequately describe patients' conditions when there are so many boxes to check and blanks to fill in.

In addition, when it comes to narrative descriptions of patients' conditions, it is extremely tempting to "copy and paste," "cut and paste," and/or "copy forward" previous documentation in the EHR. The copy and paste feature allows users to use the content of another entry and to select information from an original or previous source to reproduce in another location. The copy forward capability replicates all or some information from a previous note to a current note, while the cut and paste feature removes documentation from the original location and places it in another location. In addition to the obvious potential problems for quality of care related to the use of these functions, auditors are understandably

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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.*

CMSA Moving Forward: Strategic Plan Maps the Road to the Future

Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM

CMSA is pleased to unveil an updated Mission Statement and Vision Statement and new Core Values to reflect a more relevant perspective and be more representative of case management as a profession and CMSA as the organization.

There has been great change over the past few years for us all, including for CMSA as an organization. To ensure that we are moving in a direction that will continue to add value and benefit for our members and the case management community, the CMSA Board of Directors have taken action.

CMSA is pleased to unveil an updated Mission Statement and Vision Statement and new Core Values to reflect a more relevant perspective and be more representative of case management as a profession and CMSA as the organization.

CMSA VISION STATEMENT: As an organization, CMSA envisions a future when, "Professional case managers are recognized as THE leaders in the pursuit of promoting collaboration and defragmentation within the healthcare system."

CMSA MISSION STATEMENT or Core Purpose outlines CMSA's reason for being. As an organization, it is our mission that, "CMSA is the authority for the professional practice of case management to improve the health of individuals, families, caregiver, and support systems with their communities by:

- Setting standards and best practices for case management across the healthcare continuum.
- Impacting policy to improve health outcomes.
- Providing evidence-based tools and resources to case managers."

CMSA CORE VALUES were added to our core ideology as essential and ensuring principles that guide CMSA in everything that we do.

CMSA is committed to:

- Improved consumer health outcomes
- Professional diversity, equity, and inclusion
- Cultural competency and humility
- Advocacy for the health consumer
- Integrity and ethical principles
- Promoting health equity
- Educating case managers across the care continuum
- Evidence-based quality care
- Holistic, compassionate care
- Fostering communication and collaboration
- Advancing research, innovation, and use of technology
- Fiscal accountability

With the mission, vision, and core values statements as priority, CMSA has launched a new 3-5-year strategic plan that consists of five goals designed to keep CMSA focused on a path that will achieve our mission and is true to our vision. The CMSA Strategic Plan will also allow the Board to measure progress and success and adjust when appropriate.

These five goals will catapult CMSA into a future that is strong, collaborative, valuable, and resourceful.

And it is E.P.I.C.!

E: Education: CMSA will assess and develop educational pathways to address the professional needs of case managers across the career span while embracing future technology and innovation.

P: Public Relations and Public Policy: Build awareness in public platforms; consumers and legislators to have greater impact on health outcomes.

I: Individuals/Membership: Members are the reason we exist and are the central focus of the CMSA Strategic Plan.

C: Collaborative Relationship: CMSA will investigate and establish collaborative relationships to further the mission and elevate the profession of case management.

Your CMSA Board looks forward to

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Dr. Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM, *is the current President of the Case Management Society of America National Board of Directors and Associate Chief Clinical Operations–Continuum of Care at University of Illinois Hospital and Health Sciences System. Her current passion is in the area of improving health literacy. She has recently authored her 1st book, "A Practical Guide to Acute Care Case Management." Dr. Morley has over 20 years of nursing experience. Her clinical specialties include medical/surgical, oncology, and pediatric nursing.*

The Journey from Certificant to Volunteer to Commissioner

Rebecca L. Fisco, CDMS

Like many professionals in this field, I have moved further towards the disability management practice as my career has progressed. It's been an interesting journey that has been enhanced by my becoming a Certified Disability Management Specialist (CDMS) as well as by my increased involvement with the Commission for Case Manager Certification (CCMC), which administers the CDMS examination and certification process.

My background is in psychology and community-based mental health. Early in my career, I provided end-to-end case management for individuals who had been hospitalized in state psychiatric facilities (for at least 10 years) and were ready to reintegrate into the community. My job duties included helping clients obtain Social Security Disability Insurance benefits, overseeing their treatment follow-up and compliance, and arranging housing and other services as necessary. Through my experiences in this position, I saw the importance of a holistic approach in case management: helping individuals secure access to the resources they need to be successful.

My next professional transition coincided with a move back to Ohio, where I had grown up. In 2008, I began working as a disability case manager for The Ohio State University, providing disability management services to faculty and staff, including workers' compensation, vocational rehabilitation, skills training, and transitional return-to-work (RTW) as well as nonoccupational case management for employees covered by short-term or long-term disability or other leaves.

Disability management is a specialized field with a unique set of skills and knowledge. Therefore, connecting with others in the field is extremely important, particularly to facilitate sharing information on new legislation and best practices.

In Ohio, as a monopolistic workers' compensation state, all employers are required to be insured by the state's Bureau of Workers' Compensation, which administers the program and sets forth specific guidelines for medical and service providers. To perform vocational rehabilitation services, professionals must be certified through the Ohio Bureau of Workers' Compensation and must have either a master's degree in vocational rehabilitation or must be a CDMS. To deliver the best possible outcomes for my employer and the employees with whom I work, I pursued the CDMS certification in 2012.

Disability management is a specialized field with a unique set of skills and knowledge. Therefore, connecting with others in the field is extremely important, particularly to facilitate sharing information on new legislation and best practices. This led me to pursue opportunities with professional organizations, such as serving on the Disability Management Employer Coalition's local and national boards. When I received an email from CDMS asking for volunteers to help develop and review test questions for the certification examination, I saw this as a way to connect with other disability management practitioners, express my passion for continuing education, and to give back to the profession.

As a volunteer serving on the CDMS test development committee, I deepened my understanding of disability management concepts, including in areas that were beyond my day-to-day job responsibilities. I also gained an appreciation for the development and maintenance of a nationally accredited certification examination; for example, ensuring clarity of language in both the questions and the answer choices. I found the experience so rewarding that I encouraged a colleague to join me on the test development committee, and she serves on it to this day.

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Rebecca Fisco, CDMS, *is a newly elected Commissioner 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 with its CCM® and CDMS® credentials. Rebecca is also the Associate Director of Integrated Absence Management and Vocational Services for The Ohio State University.*

A New Commissioner Perspective: Embracing the Case Management Connection in Behavioral Health Counseling

R. Keith Franklin, PhD, LPC, CEAP, LCDC, CCM, ACS

In 2008, while I was working as a counselor/case manager in an inpatient psychiatric hospital in San Antonio, Texas, I first heard about the Certified Case Manager (CCM) credential. My late mother-in-law, who was an RN and a CCM, knew that my job entailed not only mental health counseling but also providing case management services to clients. "Getting a CCM will highlight more of your skills and draw attention to what you do," she told me. Looking back, that turned out to be one of the best pieces of professional advice I've ever received. It also helped lead me to my current roles as a CCM-certified EAP psychologist with the U.S. Department of Defense and a newly elected Commissioner of the Commission for Case Manager Certification (CCM).

As I prepared for the CCM examination, I had to expand my clinical knowledge, given that my background was in behavioral health. But as I experienced taking the certification examination, the required knowledge spanned all facets of case management and in multiple care settings. Upon achieving CCM certification in August 2010, I found that I had a place within the growing diversified professional case management community.

Connecting with each individual and adopting a person-centric practice are fundamental to both mental health counseling and case management. Indeed, it is another linkage among all the health and human services disciplines.

R. Keith Franklin, PhD, LPC, CEAP, LCDC, CCM, ACS, *is a newly elected Commissioner of the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists with its CCM® and CDMS® credentials. Keith is also an Employee Assistance Program (EAP) psychologist with the U.S. Department of Defense's EAP, with more than 20 years of clinical experience.*

My Career Path

My passion for behavioral health and case management has developed over time. When I first went to college, I had aspired to become a dancer/actor. My mother, however, suggested that I also prepare to support myself; hence I graduated with a double major in psychology as well as theater and dance. As I applied for scholarships to graduate school, I had a deal with my mother: whichever program accepted me I would pursue for a career path. Psychology won out, and I became a mental health counselor. I soon found a purpose and meaning, which also tapped into the commonality with theater and performance: I love working with people.

Connecting with each individual and adopting a person-centric practice are fundamental to both mental health counseling and case management. Indeed, it is another linkage among all the health and human services disciplines.

My career path has taken me to two psychiatric hospitals, serving both inpatient and outpatient populations. At the same time, I began working in a part-time capacity with the U.S. Department of Defense, which provided me the opportunity to work in yet another care setting. Then, in 2015, I accepted a full-time position as a psychologist with the U.S. Department of Defense, in its Employee Assistance Program (EAP). My current role entails assessing, referring, and providing short-term, solution-focused counseling services, which are aligned with case management and the key care coordination component of connecting people with resources. In addition, I also provide counseling services to individuals, including our service members who are deploying overseas, as well as their families.

Often, these interactions entail using motivational interviewing techniques—asking open-ended questions and listening to people's concerns and goals. Reframing what they've said and repeating it back to them provides assurance that they've been heard.

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Utilization of Prosci's ADKAR Change Management Model as a Framework for Care Coordination and Integrated Case Management in the Veterans Health Administration

Julie Alban, DNP, MPH, AMB-BC, CCCTM, Catovia B. Rayner, DHA, MSW, LCSW, and Robert Larson, LCSW, ACM-SW, VHA-CM

The Care Coordination & Integrated Case Management (CC&ICM) framework incorporates Prosci's ADKAR (Awareness, Desire, Knowledge, Ability, and Reinforcement) change management model. These five elements are building blocks of the model and must be in place for change to be actualized.

The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care to approximately 9 million enrolled veterans at nearly 1,300 health care facilities each year (Veterans Health Administration, 2022). Care Coordination & Integrated Case Management (CC&ICM) is a VHA initiative that was launched in 2016 as a partnership between the Offices of Nursing Service and Care Management and Social Work Services, and the main goals of this initiative are to standardize and integrate care coordination services across all VHA facilities (Duan-Porter et al., 2020). The CC&ICM framework incorporates Prosci's ADKAR (Awareness, Desire, Knowledge, Ability, and Reinforcement) change management model. These five elements are building blocks of the model and must be in place for change to be actualized (Prosci, n.d.-b). Utilization of change management models, especially for large-scale initiatives such as CC&ICM, helps promote engagement at the individual level to drive organizational results and outcomes (Prosci, n.d.-c).

CC&ICM is a holistic approach to care that addresses fragmentation and duplication of services; provides structure to support interprofessional collaboration, coordination, and communication; and promotes optimal utilization of health care resources. The CC&ICM model was deployed across the VHA in three phases, starting in October 2021, with full implementation

Julie Alban, DNP, MPH, AMB-RN, CCCTM, VHA-CM, *is a Field Consultant for the Southeastern States Network Consortium, Veterans Health Administration. She has over 25 years of nursing experience in various roles as a critical care staff nurse, nurse educator, ARNP, and chief nurse, primary care. She has served on care coordination taskforces and helped create the certification examination on Care Coordination Transition Management.*

Catovia B. Rayner, DHA, MPH, MSW, LCSW, *is a Field Consultant for the Southeastern Network Consortium located at the VISN 8 Network Office. In her previous role, she served as the Chief of Social Work Service in the Tennessee Valley Health Care System. She has extensive experience in healthcare management and service delivery related to program implementation to enhance the veteran experience. Since 2016, Dr. Rayner has worked with the VA National Social Work and Care Management Office in the implementation of the Care Coordination & Integrated Case Management (CC&ICM) framework in the VHA.*

Robert Larson *is a Care Coordination & Integrated Case Management (CC&ICM) Field Consultant for the Southeast States Network Consortium, which includes VISN's 6, 7, 8, 9, and 16. He joined the VA in 2008 as Assistant Chief at the Bay Pines VA Healthcare System, where his last position was Assistant Chief of Social Work. Mr. Larson is an LCSW in both New York and Florida, and he is also a Certified Case Manager (ACM-SW)*

anticipated by June 2024. There are five milestones in the CC&ICM model that align with ADKAR. Each CC&ICM milestone includes critical actions.

The first CC&ICM milestone of leadership awareness aligns with the element of awareness in ADKAR, which identifies the need and reason for change. This includes explaining opportunities that have resulted in the need to change and risks associated with not changing (Prosci, n.d.-a). Lack of awareness regarding the rationale for change has been reported as the main reason for employee resistance (Prosci, n.d.- a). Methods to build awareness of the CC&ICM model include community of practice calls, intranet resources, newsletters, and presentations to and bidirectional communication with key stakeholders.

The next milestone of facility readiness aligns with the second ADKAR element of desire. Awareness of the need to change may not result in the desire to change; therefore, change management plans require key leaders and team members to help as coaches with the implementation process (Prosci, n.d.-b). A critical action in this milestone is the identification of cochampions, a registered nurse (RN) and a social worker who serve as change agents and help strategize and inspire stakeholders to achieve organizational goals.

The following milestone of implementation preparedness aligns with the third ADKAR element and includes providing CC&ICM stakeholders with educational tools such as implementation templates, training videos, communication toolkits, an interactive guide, examples of lessons learned, and best practices. Additionally, CC&ICM consultants provide mentorship, training, and resources to support implementation and change processes.

The systems and clinical integration milestone captures the fourth ADKAR element through implementation of eight critical actions: risk stratification, assessment of complexity, assignment of a lead coordinator by a care coordination review team (CCRT), evaluation of whole health needs, developing trusting partnerships, integrating care, monitoring veteran progress, and reviewing experience of both veterans and employees, These eight critical actions include a variety of strategies that address changes in clinical practice and a systems approach that create enterprisewide integration. Specifically, the CCRT, comprised of key stakeholders from the health care system, focuses on identifying a lead coordinator instead of developing a treatment plan. The lead coordinator is an individual who is identified by the CCRT as the most appropriate for either a care or case management role, coordinating the veteran's engagement with the health care system.

The final milestone, governance structure, aligns with the fifth ADKAR element, which focuses on reinforcement for sustained change and delivery of expected results over time (Prosci, n.d.-b). Sustainment is supported through deployment of CC&ICM committees, publishing facility level policies, and monitoring and reviewing progress through national dashboards.

Each of the CC&ICM milestones strategically support implementation of this initiative through utilization of Prosci's ADKAR change management model. Over the span of the implementation timeline, each element of the model is addressed and builds towards sustained change to standardize and integrate care coordination services across VHA. CM

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A Theoretical Grounding for Intensive Case Management

Holly Sanford, RN, CCM, and Harrison Dinsbeer

I lead a small team of case managers who treat acute Medicare clients with psychological and social issues that cannot be addressed properly by telephonic case management. The challenges of this exhilarating, often disappointing, and meaningful work have driven me to find a consistent approach to intensive case management. What follows is the theoretical grounding of our practice, from referral to discharge.

First, we seek to establish a relationship of trust by strategically prioritizing the client's needs and by showing unconditional positive regard.

Need Prioritization

Two principles help us choose which of the client's needs we address at the start of care. First, we must keep the client alive. For example, those of us with psychiatric training may identify a personality disorder as the root of a client's problems, but if her pantry is empty, she doesn't need counseling today—she needs food. Second, we must set the client at ease and show her respect by working on what she sees as urgent. If the client is more anxious to get in touch with a relative than to see a doctor for her back pain, we facilitate a call with the relative. When the client trusts us to address what she sees as important, she will also trust us when we identify something else as important.

Holly Sanford, RN, CCM, *is a psychiatric nurse, a case manager, and the president of Sanford Healthcare Solutions, a small case management agency in Jacksonville, Florida.*

Harrison Dinsbeer *is a case manager and communications consultant with Sanford Healthcare Solutions.*

To be effective in treating clients with acute needs, providers must maintain what Carl Rogers called "unconditional positive regard"—an accepting and caring attitude that makes no distinctions based on the client's behavior or the provider's biases. Maintaining unconditional positive regard will help you treat the client kindly and will enable you to do more than what can be reasonably expected of you—and experience tells us that many of our patients need more than what can reasonably be expected of us.

Unconditional Positive Regard

To be effective in treating clients with acute needs, providers must maintain what Carl Rogers called "unconditional positive regard"—an accepting and caring attitude that makes no distinctions based on the client's behavior or the provider's biases (Rogers, 1957/1989).

In many cases, the case manager is the first person in years to make consistent contact with the client without giving up on him or her. Maintaining unconditional positive regard will help you treat the client kindly and will enable you to do more than what can be reasonably expected of you—and experience tells us that many of our patients need more than what can reasonably be expected of us.

In his seminal essay "The Necessary and Sufficient Conditions of Therapeutic Personality Change," Rogers hypothesizes that six conditions (including unconditional positive regard) are sufficient to produce growth in a person when met concurrently (Rogers 1957/1989). And Rogers asserts that his theory is not limited to strictly psychotherapeutic contexts (Rogers 1957/1989). Conversations between case managers and clients or between two friends, for that matter, will produce personality change if the six conditions are met.

Whether true or not, this theory creates expectations since it claims to be sufficient to produce change. But in order to maintain unconditional positive regard, we must jettison all expectations. We reject all suggestions

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CE1 Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on April 15, 2023

Behavioral Health Developments for Postacute Care Networks

Laura Kukral, MBA, LNHA, and Adrienne Green, MSW, LISW-S

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime, and the burden of mental illness to the nation, both socially and financially, is among the highest of all diseases (U.S. Department of Health & Human Services, 2022). Included in the statistics is the growing number of older adults living with serious mental illness, which results in significant functional impairment that interferes with or limits major life activities (SAMHSA, 2021). According to the U.S. Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), in 2020 3.4% of people aged 50 and older had a serious mental illness (SAMHSA, 2021), meaning that an estimated 3.9 million older adults were diagnosed with schizophrenia, bipolar disorder, and severe or treatment-resistant depression with functional impairment (SAMSHA, 2021). The increasing number of people aged 50+ who are diagnosed with a serious mental illness coincides with the rapid growth of the age cohort itself. The U.S. Census Bureau reports that the older population (65+) is projected to double in size from 49 million in 2016 to 95 million in 2060 (Vespa et al., 2020).

Research also suggests mental health conditions and chronic disease are highly correlated and bidirectional. In a peer-reviewed article published by the Centers for Disease Control and Prevention (CDC), researchers found that "mental illnesses and chronic diseases are closely related. Chronic diseases can exacerbate symptoms of depression, and depressive disorders can themselves lead to chronic diseases" (Chapman et al., 2005). The implication of co-occurring mental health and chronic illness as well as projections that adults who reach the age of 65 have a 70% lifetime risk of needing long-term care services and support (U.S. Department of Health and Human Services, 2019) is that post-acute care networks will frequently be called upon to collaborate on complicated person-centered care plans that address clinical care, competing payor requirements, issues with provider availability, and the social determinants of health that lead to illness and hospitalization.

Trends in Demand

In 2019, an estimated 10.8% of adults in the United States were estimated to have symptoms of anxiety disorder or depressive disorder (National Center for Health Statistics, 2021). By July 2022, over 33.3% adults reported symptoms—a threefold increase (National Center for Health Statistics, 2022). Although younger adults reported the highest rates, symptoms were reported by 32% of adults aged 50–59, 23% of those aged 60–69, 17.7% of those aged 70–79, and 18.7% of those aged 80 and above (National Center for Health Statistics, 2021). A similar increase in suicidal ideation has also been reported (Czeisler et al., 2021). Experts say this may be the beginning of a widespread outbreak of mental illness after the pandemic. A researcher at the Johns Hopkins Bloomberg School of Public Health explained that just one-third of adults function normally after wars, pandemics, terror attacks, and natural disasters but others can become immobilized or hyperactive and hypervigilant (Ordway, 2020).

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According to the U.S. Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), in 2020 3.4% of people aged 50 and older had a serious mental illness, meaning that an estimated 3.9 million older adults were diagnosed with schizophrenia, bipolar disorder, and severe or treatment-resistant depression with functional impairment.

Despite these indications of increased need for services, a claims data analysis reflects a decline in the use of behavioral health services covered by third-party payors during the pandemic and an increased use of services not covered by insurance such as Employee Assistance Programs and digital platforms offering virtual counseling (Coe et al., 2021).

Older adults may be even more at risk for behavioral health crises than can be captured in lagging statistical reports. People aged 85 and older living in the United States have the highest suicide risk of all age groups, with a rate of 20.86 per 100,000 dying by suicide in 2020 (CDC WISQARS, 2022). Seniors are also reported to be underdiagnosed, undertreated, and often are caregivers for others, which further increases their risk of becoming anxious or depressed (Fleet et al., 2022).

In sum, delivery of post-acute care services for older adults is expected to be increasingly complicated by behavioral health comorbidities. As baby boomers age, more and more are expected to need behavioral health services.

Barriers to Access

Barriers to accessing behavioral health services for older adults include those that apply to the general population and some that are unique to the aging population. A dire shortage of counselors and psychologists is a barrier affecting access for all age groups. Barriers exacerbating access issues for older adults include identifying or accepting the need for help; costs, coverage, and confusion about payor coverage of care; transportation; a reluctance to use virtual services; and lack of coordination between payors (Medicare and Medicaid) for medical and behavioral care.

Lack of Workers

"'We're in crisis," said Lori Criss, the director of Ohio's Department of Mental Health and Addiction Services. "The increased demand for mental health and addiction services is far outpacing the available supply of professionals and paraprofessionals who deliver those services" (Schneck, 2022). In Ohio, demand for behavioral health services increased 353% between 2013 and 2019 while the behavioral health workforce grew at half the pace. At the national level, the 2017 prepandemic projections indicated that by 2030 there will be a 20% decrease in supply of adult psychiatrists and a 3% increase in demand for them (HRSA, 2021). Currently, nearly 155 million people in the United States live in one of 6,374 area with a shortage of mental health professionals and where nearly 8,000 practitioners are needed (HRSA, 2022). The lack of geriatric psychiatrists is even more concerning. Among the 6,976 active residents enrolled in psychiatry programs in the United States during the 2020-2021 academic year, just 44 were enrolled in a geriatric subspecialty (ACGME, 2021).

Lack of Acceptance

At the May 18, 2022, hearing of the U.S. Senate Special Committee on Aging (the "Hearing"), Dr. Erin Emery-Tiburcio of Rush University Medical Center testified that the stigma about mental health and substance abuse is not only a barrier to mental health treatment for older adults but "is compounded by systemic ageism at policy, provider, community, and individual levels that has resulted in severely limited access to effective care" (United States Special Committee on Aging, 2022). Providers face resistance to mental health services for seniors as a two-fold challenge: a reluctant individual and resistant policy makers.

Lack of Coverage

Senators attending the Hearing also learned that while Medicare provides much of the coverage for older adults, reimbursement rates for mental health services are low. Seniors are often left few options for finding providers since psychiatrists are the most frequent providers to opt out of Medicare and Medicaid programs (United States Special Committee on Aging, 2022).

In addition to low provider pay, numerous other payor issues also create barriers to care for older adults seeking comprehensive community-based services. For example, most Medicare Advantage programs do not pay for Community Psychiatric Supports and Treatment services. If Medicare Advantage customers do not have access to Medicaid-covered services, they face the financial challenge of paying out of pocket for services.

Lack of Coordination

Sixty-four percent of dual-eligible beneficiaries of both Medicare and Medicaid have a mental health diagnosis (ATI Advisory, June 2022). Since state Medicaid managed care

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programs contract behavioral health services to another payor, dual beneficiaries may be affected by a lack of integration between physical health and behavioral health care services (ATI Advisory, 2022). The Centers for Medicare & Medicaid Services (CMS) acknowledged behavioral health conditions as a "full blown crisis" in July 2022 including issues caused by failing to coordinate care between physical and mental diagnoses and between the payors (Seshamani et al., 2022). CMS subsequently announced a new strategic plan promising to fund new smaller accountable care organizations to hire behavioral practitioners and address social needs such as food and housing (Seshamani et al., 2022).

Inspiration for Curators of Post-Acute Care Networks

Stepped-Care Model

Post-acute care providers say the ideal behavioral health program incorporates psychiatry, psychology, and medication, but there is a lack of consensus for an optimal model of care in skilled nursing facilities (Plys et al., 2022). A stepped-care model of behavioral health has been proposed to clarify the scope of practice for licensed behavioral health professionals working in nursing homes and potential policy changes for integrated care in skilled nursing facilities (Plys et al., 2022). This model focuses on optimizing resource allocation by providing the least-resource intensive intervention first, with evidence-based steps-up in care if needed.

Collaborations

Hospital systems are increasingly forming various types of collaborations with other providers to address specific demand issues such as post-acute care and geriatric behavioral health. These ventures may include development of off-site facilities that can free up inpatient medical-surgical beds and appropriately divert patients who might otherwise board in emergency departments. At University Hospitals Lake Continuing Care Center in Concord, Ohio ("campus"), a freestanding campus was developed to include Lake Hospital's Center for Comprehensive Rehabilitation and the Center for Geriatric Psychiatry, which is managed by Horizon Health. The campus is also home to one of the hospital's post-acute care network members: Concord Village Skilled Nursing and Rehabilitation (Concord Village SNR). Within University Hospitals Lake Health there are multiple levels of behavioral health care. Embedded in each of the two emergency departments are 24/7 crisis teams, funded primarily through the county Alcohol, Drug Addiction & Mental Health Services board. Consulting teams comprised of clinical social workers and psychiatric advanced practice providers assess and treat patients on medical units. Another team of psychiatric advanced practice providers lead a "House Calls" program, providing behavioral health care in patients' homes and long-term care facilities. Their team also includes a nurse case manager. The inpatient geriatric psychiatry unit provides care to older adults experiencing a mental health crisis. The Center for Geriatric Psychiatry partners with Horizon Health, which provides operational expertise and management services and guidance on regulatory and payor requirements while the hospital leads strategic, programmatic, and clinical development.

An executive of Concord Village Skilled Nursing & Rehabilitation and one of the collaborators explained that the skilled nursing facility located at the campus was designed to provide state-of-the-art, post-acute care, skilled nursing, and rehabilitation services rather than behavioral health specialty care. The high-volume nursing home's top diagnoses groups are circulatory and injury related (Trella Health, 2022). It served 173 distinct patients in the most recently available quarter of independent data including 89 patients covered by Medicare fee-for-service, 68 covered by Medicare Advantage, and 30 covered by Medicaid with a 30-day readmission rate of 12% for Q4 2021 (Trella Health, 2022). Most older adults have physical and behavioral comorbidities. Concord Village Skilled Nursing & Rehabilitation typically admits patients for skilled rehabilitation and addresses mental health needs as part of the plan of care. If inpatient mental healthcare is the primary need, the hospital's patients receive care from the Center for Geriatric Psychiatry.

Military models

In the military, behavioral health technicians are enlisted service personnel who provide behavioral health screening and assessment, outreach, psychosocial intervention, and case management (Holliday et al, 2022). President Biden's recently announced strategy to address the national mental health

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crisis signals accommodations may be near for broader use of trained paraprofessionals to supplement mental health capacity. According to the White House, over $225 million in training programs to increase the number of community health workers will be made available in fall of 2022 (The White House, March 1, 2022).

Evidence-based programs
The National Council on Aging (NCOA) promotes several evidence-based programs for older adults with mental illness. These include Healthy IDEAS, PEARLS (Program to Encourage Active, Rewarding Live for Seniors), and BRITE (Brief Intervention and Treatment for Elders). More information about these programs is available at NCOA's website.

Certified Community Behavioral Health Clinics
A Certified Community Behavioral Health Clinic (CCBHC) model is designed to provide coordinated behavioral health care to anyone who requests care regardless of their ability to pay. CCBHCs must help their clients navigate services to meet their behavioral, physical, and social services needs. The clinics are supported by Medicaid demonstration grants administered through SAMHSA or state programs. More information about these clinics is available at SAMHSA.gov.

What Care Managers Can Do

Invest in Communication Skills
Care managers are frequently so consumed with the immediate clinical, social, and behavioral needs of their assigned patients that there is little time during the workday for thinking about much else. However, lifelong investments in the development of advanced communication skills can be very helpful in reducing misunderstandings and poor handoffs with patients, other providers, and family caregivers. If you are a post-acute care or community care manager involved with a client transfer to acute care with a behavioral health emergency, clear communication about symptoms with both responding emergency medical technicians and emergency department staff is essential for proper triage and treatment. Facilitate warm handoffs whenever possible to ensure the correct information gets to the right people. Talk to the receiving provider live, not just by email or other forms of electronic communication.

Develop Local Knowledge
As a value-added skill, develop expertise and relationships with payors in your market area, particularly the Medicare Advantage plans that offer (require) behavioral health care management and support.

Build Relationships
Network professionally. Go to meetings where you can meet care managers from other settings. Keep their names and contact information. Keep up with personnel changes as much as possible. These connections become points of access for services for your patients.

Pursue Change
The abruptness of the COVID-19 pandemic demanded care managers adopt changes in the traditional workflows and care management operations. Care managers must currently avoid slipping into passive discharge planning roles and instead work to align all orders to the patient's goals and criteria for insurance coverage or ability to pay privately. According to an experienced care manager, "it is incumbent on (care managers) to be well versed in the medical, functional, and financial criteria for transferring a patient to acute rehabilitation or to any other post-acute level of care (McLaughlin et al., 2022).

Think Strategically
Care managers are strategists. They are required to think strategically on behalf of patients every day. Care managers gather information, identify options, evaluate the business case of various services, consider constraints, facilitate decisions, and launch implementation plans. These skills transfer to the strategic development of post-acute care networks. The data presented above suggests that network curators need to evaluate their strategies to ensure solutions for the behavioral health needs of older adults as well as physical needs.

A two-pronged approach to a post-acute care network design strategy might make sense based on the expected volume of patients admitted with primary diagnoses of mental

health conditions. If a high volume of geriatric psychiatry patients is expected, post-acute care networks curators may need to include providers offering specialized and secure behavioral health programming and facilities. Other curators may want to collaborate with network members to develop standards of care and key performance indicators to ensure older adults with behavioral health comorbidities are treated holistically.

Even if unmet behavioral health needs are not yet identified as outcome concerns for your senior care service lines, the data suggest they will be soon. Thankfully, care managers are already skilled at presenting options to address behavioral health services and, hopefully, they will integrate this knowledge in the design of post-acute care network strategies. CE1

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Adult Day Services: A Valuable and Vital Partner for Care Managers

Jed D. Johnson, MSW, MBA, Merle D. Griff, PhD, and Cathy Cooke

Introduction and Overview

Long referred to as "the best-kept secret in long-term care," the recent proliferation of adult day services is the direct result of aligning demographic and environmental factors. This includes an overwhelming preference for home- and community-based care options; projections that the number of Americans age 85 and older, the group most often needing additional support, will nearly quadruple between 2000 and 2040 (Urban Institute); along with the affordability of adult day services when compared with other care alternatives and a growing number of payor options. As a result, adult day services are a valuable and vital partner for care managers.

We provide a brief overview of adult day services, including the positive impact centers have on the health and wellness of both adult day services participants as well as their family caregivers and other supports. For care managers, adult day services can serve as their "eyes and ears," able to provide ongoing assessments, real time data, and regular status updates. Brief case scenarios offer further insights into the adult day services/care manager relationship including examples of how adult day services can be a solution for a variety of challenging situations. Information will be shared on who pays for adult day services, selection criteria for adult day services, and where to find adult day services in your local area. Emerging trends across the adult day services industry include the increased use of innovative technologies. Finally, a curated listing of adult day services resources is provided.

Adult Day Services

As defined by the National Adult Day Services Association (NADSA), "Adult Day Services is a system of professionally delivered, integrated, home and community-based, therapeutic, social and health-related services provided to individuals to sustain living within the community." (NADSA, 2022) According to the 2020 National Post-Acute and Long-Term Care Study, there are approximately 4,100 adult day services centers in the United States supporting nearly 240,000 participants (both older adults as well as adults of all ages with acquired and/or life-long developmental disabilities). (CDC National Center for Health Statistics, 2022) Data from their 2018 study are shared below (Lendon, J.P. and Singh, P., 2021).

Demographic Profile of Adult Day Services

- Nearly 2/3 of persons served need assistance with 3+ activities of daily living (ADL)
  - 75% needed assistance with bathing

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Cathy Cooke *is the Director of Marketing and Communications at SarahCare© Adult Day Health Centers. During her 25+ years in various healthcare settings, Cathy has seen families struggle to find comprehensive quality care for their loved ones, most of whom were unaware that adult day services were available. A member of the SarahCare team for 8 years, Cathy has helped to develop new health and wellness programs. Her goal to spread the word about the numerous adult day health services that benefit and improve the quality of life for seniors as well as their caregivers.*

Long referred to as "the best-kept secret in long-term care," the recent proliferation of Adult Day Services is the direct result of aligning demographic and environmental factors.

  - 64% needed assistance with dressing
  - 58% needed assistance with walking/locomotion
  - 53% needed assistance with toileting
- 39% of persons served were under age 65 and 19% were age 85+
- Adult day services are more racially and ethnically diverse than other long-term care alternatives
  - 45% Non-Hispanic White
  - 22% Hispanic
  - 17% Non-Hispanic Black
  - 16% Non-Hispanic other
- Most persons served have multiple chronic conditions
  - 51% hypertension
  - 30% diabetes
  - 28% Alzheimer's disease or other dementias
  - 21% depression

Impact and Benefits of Adult Day Services

A unique aspect of adult day services is the dual emphasis in supporting participants along with their family caregivers and other supports. As cited in ARCH National Respite Network & Resource Center's Adult Day Services and Respite fact sheet, "Research has shown that ADS programs reduce caregiver depression, stress and burden levels linked to caregiver health and well-being (Fernia et al., 2007; Fields et al., 2014; Zarit et al., 2011; Zarit et al, 2014). In addition to providing respite, centers may provide caregivers with a community of support as they look after their loved one." (ARCH National Respite Network & Resource Center, 2022). Most centers provide caregiver support programs, including educational programs (70%), caregiver support groups (58%), and individual counseling (40%) (NADSA, 2022). Employers of working caregivers whose loved ones attend adult day services report increased productivity and reduced time away from work (The Gerontologist, 2017).

For adult day services participants, there is the overarching benefit of remaining at home versus moving into a residential setting. According to an AARP (American Association of Retired Persons) survey, over three-quarters of Americans age 50 and older (77%) indicated they prefer to remain in their current residence or community for as long as possible as opposed to a senior care facility (AARP, 2021).

With nearly 80% of all adult day services having full- or part-time nursing professionals on staff and over 50% indicating there is a social worker on their team, adult day services participants are able to access a variety of health-related and social services (NADSA, 2022). This includes engaging in therapeutic activities, mitigating social isolation, supporting chronic disease management, and providing assistance with activities of daily living. Evidence shows that adult day services participants have a better quality of life including health-related, social, psychological, and behavioral benefits for participants, particularly those with dementia and other cognitive impairments. And while additional research is needed, adult day services may help decrease the incidence of preventable hospital readmissions for managed care organizations (The Gerontologist, 2017).

In addition to benefiting their clients, adult day services offer care managers ongoing real-time access to vital information including regular monitoring and updates. The following three case scenarios examine the topics of medication management, depression, and abuse/neglect, thus offering additional insights into the value of the adult day services /care manager relationship.

Case Scenarios

Scenario #1: Medication Management

Polypharmacy is a concern among older adults and often a challenging issue facing care managers because many individuals do not correctly report to their physicians and other health care providers all the prescriptions, over-the-counter medications, and other medications they take and the dosage details. For most adult day services programs, nursing staff (and in some locations, consulting pharmacists) regularly review all prescription and nonprescription medications. If it is believed that there could be negative medication interactions, side effects, or other medication-related concerns, the physician(s) and care manager are contacted. Here is one example where regular adult day services attendance averted a potential health crisis.

Living alone, Chris was referred by his care manager and enrolled in the adult day services center, attending 3 days a week. After a few months, adult day services staff approached Chris' care manager sharing that Chris was "just not the same." Chris had been active and energetic and now was very lethargic and, at times, he seemed confused. When the center's nurses completed their assessment, they found that in addition to the medications prescribed by multiple physicians, Chris was continuing to self-administer medications

that should have been discontinued and had begun taking a supplement seen advertised on TV. The consulting pharmacist confirmed that there was a strong likelihood of medication interactions.

The center's RN notified Chris' primary care physician, who quickly responded and worked with the participant's pharmacist so that Chris would be receiving the proper medications in the appropriate doses. The RN also notified the care manager who discussed the changes with the family and with the center's nurse, who helped them establish a system for ongoing medication management and monitoring. Over the course of the next month, center staff and family noted that Chris had returned to his prior more energetic self.

Scenario #2: Depression

As social circles become smaller after retirement and older adults experience physical decline and loss due to the death of loved ones, increased loneliness, isolation, and depression may be observed. Depression is not a normal part of aging, a sign of weakness, or a character flaw. Many older adults with depression need treatment to feel better. The recent COVID-19 pandemic disproportionately impacted older adults and served to further exacerbate social isolation and these related concerns.

Adult day services provide the socialization and interaction that home-based services cannot. Older adults actively engage in meaningful and purposeful activities and build new relationships with their contemporaries. Through the implementation of tools such as the Patient Health Questionnaire-9 (PHQ-9), care managers can document the positive impact adult day centers are having on the lives of the nearly one quarter of their participants with a diagnosis of depression. Following a visit to Jamie's primary care physician, Jamie's care manager was asked to consider enrolling him in adult day services. The physician felt that Jamie was isolated and increasingly lonely following the death of his spouse. There was increased concern as Jamie's scores on the PHQ-9, administered during office visits, were continuing to indicate increased depression. The physician felt that socialization and interaction with peers could help with Jamie's mental state.

Within 3 months of starting the adult day services program, and with regular attendance at the center, Jamie's care manager received a report indicating that Jamie had made friends, was going on weekly outings, and participating in activities. Several of the friends had also lost their spouses, and they offered informal support to one another. Jamie enjoyed participating in the programs and activities and began looking forward to coming to the center. It soon became evident that Jamie was also beginning to pay more attention to self-care. Subsequent scores on Jamie's PHQ-9 screenings showed a significant decline in Jamie's level of depression.

Scenario #3: Abuse and Neglect

Every year, an estimated 4 million older Americans are victims of physical, psychological, or other forms of abuse and neglect. Research also indicates that elder abuse and neglect is most likely to take place in the home, with no single pattern to the abuse. Self-neglect occurs when an individual no longer cares for themselves and may stop eating, bathing, or taking medications.

Staff in adult day centers are trained to identify possible abuse or neglect and are constantly evaluating individuals for signs that this may be occurring. When suspicions arise, nurses, program directors, and other adult day services staff are trained to report them to the participant's care manager, physician, and/or to Adult Protective Services. In this instance, the adult day center team and the care manager came together to protect and advocate for the well-being of every individual in their care while also supporting family caregivers.

A longtime 2-day-a-week adult day services participant with mid-stage Alzheimer's disease, Alex was beginning to come into the center with bruises that were hidden by clothing. Personal care aides who assisted Alex in the bathroom immediately reported the bruises to the center's nurse. The nurse did not think that the bruising was a result of medications or disease process; per procedure, the nurse took photos and measured the bruises indicating the location, appearance, date, and time. The nurse immediately followed up with the family caregiver.

The caregiver indicated that the bruising was likely caused by Alex's frequent falls. The nurse acknowledged this response and shared that per program protocols a report would be filed with the area's Adult Protective Services team and that Alex's care manager would be apprised of the situation. The results of the investigation found that the caregiver was becoming increasingly frustrated and exhausted, resulting in these injuries. After this intervention, the care manager hosted an interdisciplinary care planning meeting held at the adult day center. Collectively, they agreed upon a path forward that included arranging for Alex to increase attendance to 5 days per week, to receive supplemental counseling and caregiver support, and to be temporarily relocated to live with another family member. Over time the situation stabilized and family members began collaborating in Alex's care. Alex was able to return to his former home and the adult day services team continued to provide support for all involved and to monitor the situation.

As defined by the National Adult Day Services Association (NADSA), "Adult Day Services is a system of professionally delivered, integrated, home and community-based, therapeutic, social and health-related services provided to individuals to sustain living within the community."

Finding and Selecting an Adult Day Center

There are a number of resources care managers and/or their clients can access to identify local adult day services options. The National Adult Day Services Association hosts a searchable directory of adult day centers. In addition, many states have an adult day association and/or a governmental website with state-specific information. The federal government's Eldercare Locator can be accessed online or toll free via phone. Care managers and/or clients will then be directed to either their local Area Agency on Aging or their Aging & Disability Resource Center who maintain up-to-date databases of all adult day services providers in their region. Additional resources related to finding and selecting an adult day services program include the Alzheimer's Association, the National PACE Association's PACEFINDER, and the ARCH National Respite locator. See the Resources section for additional information.

When selecting an adult day center, the National Adult Day Services Association has a number of helpful resources such as their Questions to Ask When Visiting an Adult Day Center (NADSA, 2022). Licensing and regulatory oversight of adult day programs varies considerably from state to state. A growing number of providers are seeking accreditation through an independent outside organization, with CARF International selected as the industry's preferred provider offering a comprehensive adult day services quality framework.

Cost of ADS

The cost of adult day services varies depending on a variety of factors such as geographic region and the range of services provided. According to the 2021 Cost of Care Survey from long-term care insurance company Genworth, the median cost across the United States for adult day services is $1,690 a month, or approximately $78 per day (Genworth, 2021). This compares quite favorably to the other long-term care options included in the survey. Pricing models also vary considerably from center to center, with some using level-of-care models, hourly vs. full or ½ day rates, volume discounts (for those attending a higher number of days per week), "bundled vs. unbundled" charges for additional services such as bathing and transportation, and the availability of needs-based scholarships or discounts.

Who Pays for Adult Day Services

- Medicaid (including Medicaid waivers and Medicaid managed care)
- Department of Veterans Affairs (VA)
- Program of All-Inclusive Care for the Elderly (PACE)
- Older Americans Act and National Family Caregiver Support Program (through state programs)
- Lifespan Respite (through state programs)
- Long-term care insurance
- Disease-specific financial support (eg, for persons with multiple sclerosis, amyotrophic lateral sclerosis, or other diagnoses)
- Private pay
- Dependent care tax credits

Currently providing reimbursement for nearly three-quarters of all adult day services attendees nationwide, the primary federal payor for adult day services is Medicaid including both Medicaid waivers and Medicaid managed care plans (CDC National Center for Health Statistics, 2022). In general, Medicare does not cover the cost of adult day services, although this may begin to change. With the passage of the CHRONIC Care Act, the Centers for Medicare & Medicaid Services (CMS) issued new regulations in 2018 allowing Medicare Advantage plans to provide supplemental benefits including adult day care and respite.

The Department of Veterans Affairs either provides directly or contracts for eligible veterans to receive Adult Day Health Care through the Geriatrics and Extended Care division of the Veterans Health Administration. Veterans do not need to have served during a time of war in order to qualify for services. Other federal programs that may offer funding support include: Older Americans Act, National Family Caregiver Support Program, Community Development Block Grants, Lifespan Respite, PACE, and others. Note that there is considerable variation from state-to-state.

Emerging Trends in ADS

Before the COVID-19 pandemic, a limited number of adult day services programs offered opportunities for virtual engagement of participants and/or families/other supports or supplemental in-home supports. While the data have yet to be analyzed, hybrid home-based and virtual adult day services

A unique aspect of ADS is the dual emphasis in supporting participants along with their family caregivers and other supports. As cited in ARCH National Respite Network & Resource Center's Adult Day Services and Respite fact sheet, "Research has shown that ADS programs reduce caregiver depression, stress and burden levels linked to caregiver health and well-being."

models appear to have expanded significantly. Examples of technology innovations include making portions of the daily activity program available virtually for participants who need to remain home because of positive COVID tests. Other emerging trends in the field include extended and overnight availability of adult day services and intergenerational shared site programs. Examples of both of these innovative approaches are highlighted in ARCH National Respite's *Adult Day Services and Respite factsheet* (ARCH National Respite Network & Resource Center, 2022). The organization Generations United is a strong voice supporting the development and expansion of intergenerational programs bringing children, youth, and older adults together. This includes support for intergenerational shared site adult day services programs.

Conclusion

Adult Day Services offers care managers, clients, and their caregivers a cost-effective and valuable alternative to other long-term care options. A win-win-win for all. Ancillary services such as podiatry and hair care can help eliminate the need for outside appointments, additional transportation, or additional time off work for the caregiver. Adult day center staff are members of the participants' health care team, providing nursing care as well as medication management and monitoring of chronic and acute disease process in addition to other health and wellness services. Participants also receive personal care, assistance with activities of daily living, delicious and nutritious meals, socialization, and peer interaction. Multidisciplinary approaches address physical, mental, and spiritual well-being and all for significantly less than the cost residential or home care options. Care managers can visit multiple clients on the same day at the center while receiving real-time data and information from the staff. Adult day services are truly a valuable and vital partner for care managers. CE II

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CE3 Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on April 15, 2023

A Lesson Learned in Improving Colorectal Screening Outcomes

Lisa Parker-Williams, DNP, MBA, RN, CCM

Colorectal cancer (CRC) is the second-leading cause of cancer deaths among men and women in the United States. The American Cancer Society's Cancer Facts & Figures 2021 report projects 149,500 new cases of CRC and over 52,980 CRC deaths in 2021 (United Health Foundation, 2022). As a Doctor of Nursing Practice (DNP) student, I did research to determine if CRC screening outcomes would improve with educational interventions. The intervention aimed to determine if primary care practice team education and evidence-based toolkits improved patient adherence to CRC screening. This intervention interested me as a nurse and a certified case manager. The Case Management Society of America (CMSA) defines case managers as "…healthcare professionals who serve as patient advocates to support, guide and coordinate care for patients, families, and caregivers as they navigate their health and wellness journeys" (Case Management Society of America, 2022).

The project involved three primary care practices that were considered a group in the health payor value-based program. The group had a combined population of approximately 5,000 members attributed to this specific health payor, with 25% of that combined population eligible for the CRC screening HEDIS measure for the 2019 program year. The population included members aged 50-75 who had never been screened or were due for a repeat screening based on previous screening methods (Parker-Williams, 2021).

According to the United Health Foundation (2022), multiple studies have proven that screening for CRC is cost effective and can potentially avert approximately 24-28 CRC deaths for every 1,000 adults screened. CRC is a patient adherence challenge in healthcare settings, notably the primary care setting (Triantafillidis et al., 2017). Patient-centric screening methods can improve patient adherence while meeting patient needs. There are multiple screening methods available for detecting abnormalities of the colon. They are guaiac-based fecal occult blood test (gFOBT), FIT-DNA test, Cologuard, fecal immunochemical test (FIT), flexible sigmoidoscopy, colonoscopy, and computed tomography (CT) colonography. Although all methods are acceptable, best practice recommends the colonoscopy procedure exclusively to detect the presence of CRC (Willyard, 2014). The colonoscopy procedure can detect cancer and polyps, which can be removed during the colonoscopy without needing a second procedure. This significant advantage over other screening methods is why it is called the" gold standard" screening method for CRC (Wolf et al., 2016).

To improve adherence to CRC screening, patients at average risk for CRC should have efficient screening method options that detect disease and have a low false-positive rate. In addition, the methods need to be safe, cost effective, and readily available. Increasing patient adherence to CRC screening does not solely rely on the healthcare provider's recommendation for screening. Primary care health providers' screening methods should be easy to implement, reliable, and readily accessible to improve adherence (Chablani et al., 2016). The gFOBT and Cologuard are two convenient noninvasive screening methods, Cologuard has a retesting requirement every 3 years whereas gFOBT has a yearly testing requirement. A study by Bering et al. (2017) revealed that the noninvasive multitargeted stool DNA testing such as Cologuard is an effective and safe alternative to colonoscopy for average-risk patients. The test has a sensitivity of 92.3% and a specificity of 87% (Hamzehzadeh et al., 2017).

History

Although multiple screening options are available, screening rates for CRC remain low; the national screening adherence was 67.7% in 2018 and increased to 74.3% in 2021 (United Health Foundation, 2022). Healthcare providers must improve the methods they use to encourage patients to comply with CRC screening guidelines (Triantafillidis et al., 2017).

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Colorectal cancer (CRC) is the second-leading cause of cancer deaths among men and women in the United States, and the American Cancer Society's Cancer Facts & Figures 2021 report projects 149,500 new cases of CRC and over 52,980 CRC deaths in 2021.

According to the Surveillance, Epidemiology, and End Results (SEER) program from the National Institutes of Health, there were 38.2 new cases of CRC per 100,000 men and women between 2013 and 2017. The SEER program reported that in 2017 an estimated 1,348,087 individuals were living with CRC in the United States. CRC affects men and women (National Institutes of Health, 2019). According to Cagir (2020), males have a slightly higher incidence of CRC malignancy. The overall age-adjusted incidence of CRC for males was 48.9 per 100,000 and 37.1 per 100,000 for females from 2008-2012. Recent America's Health Rankings (2022) report that females are getting screened more than males. However, the 2021 findings show that males have increased their screening rates from 67.4% in 2018 to 71.2% in 2021. The CRC screening rates for females were 73.5% in 2018 and 71.35% in 2021. It is important to remember that the measurement year 2020 was difficult to calculate because of the COVID-19 pandemic (Parker-Williams, 2021).

Provider Implications

More than ever, healthcare providers are accountable for improving patient outcomes. For example, one of the objectives of Healthy People 2030 is to increase the proportion of individuals who discuss interventions to prevent cancer with their health care providers. This objective is a high-priority public health issue still being researched to determine evidence-based methods to support meeting this objective (United Health Foundation, 2022).

Early detection of CRC improves survival rates, improving individuals' quality of life and decreasing CRC mortality (Lauby-Secretan et al., 2018). According to Simon (2016), CRC disease contributes $14 billion to the United States' annual healthcare cost. Diligently addressing this crisis can impact cost, aligning with the triple aim tenet of reducing healthcare costs.

Although CRC grows slowly, yearly screening is more cost effective than treating a patient diagnosed with CRC. Naber et al. (2019) found that all screening methods yield significant reductions in CRC incidence and mortality. The data show that screening patients age 65 and older (using a CRC rate of 64 per 1,000 patients) can reduce lifetime total medical costs by nearly $4 million. All screening methods have a cost associated with them; however, these costs are small compared with the cost of treating newly diagnosed CRC patients (Naber et al., 2019).

Casteneda et al. (2017) conducted two pilot studies using evidence-based education strategies and provided FIT screening kits to encourage adherence to CRC screening. Both studies involved Spanish-speaking Latino adults between the ages of 50 and 75 from a large Federally Qualified Health Center who were not up to date with CRC screening. The first study consisted of a 30-minute in-person educational visit, and the second pilot was a mailing of educational material to patients. Both pilot groups received educational material, including a FIT kit with complete instructions and prepaid return mailing envelopes. The study revealed that evidence-based strategies such as patient education, the provision of test kits, and face-to-face interaction, known by the study team as in-person intervention, can improve CRC screening outcomes. The in-person pilot resulted in a 76% completion rate, while the pilot conducted by mail resulted in a 19% completion rate. In addition, the study revealed that patients are more likely to complete CRC screening when screening method education occurs in person. The above study results demonstrate that CRC rates can improve when individuals receive instruction and access to screening methods. The United Health Foundation (2022) supports using patient navigators, financial incentives, media campaigns, client reminders, and cost reduction as well as removing social determinant barriers to improve CRC screening rates (Parker-Williams, 2021).

The Journey to Lessons Learned

The DNP project was a quality improvement educational intervention designed to improve CRC screening outcomes in the primary care practice setting. The intervention aimed to determine if educating primary care practice teams and using evidence-based toolkits could improve CRC screening adherence in patients. The project was performed in one practice group comprising three individual primary care practices that were considered a group under the health payor value-based program. The group had a combined population of approximately 5,000 members attributed to this specific health payor, with 25% of that combined population eligible for the CRC screening HEDIS measure for the 2019 program year. The

To improve adherence to CRC screening, patients at average risk for CRC should have efficient screening method options that detect disease and have a low false-positive rate. In addition, the methods need to be safe, cost effective, and readily available.

population included members 50-75 years old who had never been screened or were due for a repeat screening based on previous screening methods (Parker-Williams, 2021).

The DNP project occurred during the height of the COVID-19 pandemic, and the "gold-standard" colonoscopy may not have been the best screening option for individuals who were reluctant to have this invasive procedure due to fear, anxiety, and the recommended pre-procedure preparation. In addition, the COVID-19 pandemic kept many Americans at home, and many health care providers moved towards telehealth visits. Therefore, as a backup to colonoscopy, the noninvasive fecal immunochemical CRC screening methods were recommended in place of the colonoscopy procedure (Issaka & Somsouk, 2020).

During the COVID-19 pandemic, noninvasive screening interventions such as FOBT and Cologuard were offered to improve compliance rates. The project assessed CRC screening rates before educational training and post educational training for a 4-month time frame.

The project interventions included a webinar PowerPoint presentation and three role-specific educational toolkits. The toolkits outlined the essential role that the primary care physician, medical assistant, and office manager played in improving CRC screening outcomes for average-risk patients. The presentation discussed the four essentials for improving screening rates at the primary care level, the available screening methods, and an overview of HEDIS requirements to complete CRC screening. In addition, the presentation discussed improving patient engagement through shared decision-making, motivational interviewing, and practice-driven campaigns. The educational training session was an hour, with 50 minutes of content and 10 minutes for a question-and-answer session. The toolkits contained various evidence-based knowledge translation tools and strategies to facilitate or educate behavioral change (Yamada et al., 2015). The DNP project used toolkits of algorithms, checklists, and educational material to implement behavioral change in the primary care practice.

This article focuses on the rate of CRC screenings completed and whether the use of educational webinars along with role-specific toolkits can impact CRC screening adherence (Parker-Williams, 2021).

The pre-and post-education implementation table (Table 1) displays the total number of screenings performed during 2019 and 2020. The number of screenings performed in the month is represented by n, and the percentage represents the screening completion rate for the practice. It is important to note this is an annual measure that fluctuates based on the member eligibility of the attributed practice population. The month-to-month and year-to-year comparisons show that Practice A had a month-to-month percentage increase in completed screenings in the 2020 period compared with the 2019 period. Conversely, Practice B showed minor screening fluctuations with a percentage decrease from 2020 to 2019. At the same time, Practice C started the measurement period with an increase and then demonstrated a constant decline. The fluctuation in Practice C could be related to the number of colonoscopies performed in September because elective procedures were rescheduled. On the other hand, the results for practice B indicated that many of the colonoscopy procedures performed when elective procedures resumed were because patients had other signs and symptoms that made the colonoscopy procedure the better option.

Practice A's statistically significant result was as follows: $z = -2.309$, $P = .029$. The percentage of compliance went from 51.25% in 2019 to 59.24% in 2020, indicating that singular practice improvement can occur even when other practices display the opposite. Practice A's result strengthens the concept that CRC screening outcomes can improve when clinical practice teams incorporate evidence-based models to improve adherence (Parker-Williams, 2021).

TABLE 1 PRE-AND POST-EDUCATIONAL IMPLEMENTATION

	September		*October*		*November*		*December*	
2019-Pre	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Practice A	10	47	7	49	5	51	5	51
Practice B	14	62	28	64	24	63	32	64
Practice C	11	72	13	76	7	78	5	78

2020-Pre	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Practice A	15	54	17	58	17	57	14	59
Practice B	7	57	2	58	8	57	1	58
Practice C	14	69	14	70	13	72	14	75

The Doctor of Nursing Practice (DNP) project was a quality improvement educational intervention designed to improve CRC screening outcomes in the primary care practice setting. The intervention aimed to determine if educating primary care practice teams and using evidence-based toolkits could improve CRC screening adherence in patients. The project was performed in one practice group comprising three individual primary care practices that were considered a group under the health payor value-based program.

Models such as the Systems Model of Clinical Preventive Care focus on clinician and patient communication using supportive tools to enhance patient engagement (Walsh & McPhee, 1992). In addition, using evidence-based tools, shared decision making, and motivational interviewing can improve patient and practice outcomes. The Practice A results are significant because this was the lowest performer within the group during the 2019 performance year.

The project results were surprising but understandable. The nation was experiencing a pandemic. New Jersey experienced two COVID-19 waves, and much of the state was operating under COVID-19 restrictions and guidelines (New Jersey Department of Health, 2020). The data shows a decrease in CRC screening related to New Jersey experiencing the peak of shelter-in-place restrictions during March through mid-May 2020 of the pandemic. The state entered a phase of relaxed shelter-in-place restrictions in mid-May 2020, with an upsurge in COVID-19 cases in September 2020 (New Jersey Department of Health, 2020). This upsurge caused a re-emergence of some restrictions along with patient hesitancy to resume nonemergent physician visits (Czeisler et al., 2020). Primary care practice was forced to adapt quickly to the necessary patient and practice management demands of COVID-19. The project outcomes reflect the importance of physician-patient education and communication. Primary care practice teams will need to continue to implement and use evidence-based communication tools to improve CRC screening outcomes. Sarfarty (2008) indicates that the first of the four essentials to improve CRC screening is that the physician must make a recommendation. Patients might better receive recommendations if physicians know that patients understand their CRC screening options. The impact of a recommendation can depend on the communication technique (Parker-Williams, 2021).

Implications of COVID-19

COVID-19 forced practices to use telehealth instead of in-office visits for essential health services. Telehealth visits were encouraged and promoted by the CDC and health payors (Centers for Disease Control and Prevention, 2020). It is reasonable to believe that an average-risk patient would prefer to perform an at-home screening rather than have an outpatient procedure during a pandemic. In discussing the project outcomes with the practice team members, not wanting to be hospitalized was one reason for delaying screening. The team members agreed that patients had expressed a preference to wait until the pandemic was over before completing any screenings. The fear of being hospitalized for unfavorable results during a pandemic directed their decisions. Another team member responded that many colonoscopy procedures were performed because of previous patient cancellations or positive screening results. Hospital and outpatient services could not schedule elective endoscopy procedures between March and May 2020. Elective surgeries were cancelled so that staff could assist in other critical areas during the pandemic.

CRC screening kits were mailed to eligible patients during the COVID-19 pandemic in an attempt to increase adherence. Per Jaklevic (2020), mailing CRC screening kits does not remove clinical team involvement. Many tests were mailed to eligible patients; however, the necessary follow-up did not always occur (Parker-Williams, 2021).

Lessons Learned

According to Jaklevic (2020), some patients require more than robocalls and postcards. Some patients need direct contact with their primary care clinical team to complete screening. This contact need is why clinical practice teams must be educated about CRC screening. Primary care practices need to be knowledgeable about CRC screening methods and comfortable recommending appropriate methods to average-risk patients based on health assessments. The health care continuum must improve collaboration to ensure patients receive comprehensive and consistent CRC screening messaging. Processes and workflows must be developed and consistently revised to track and monitor results. Implementing workflows designed to ask patients about preventative screenings not limited to CRC but appropriate to gender, age, and risk along every transition of care touchpoint can help improve preventive screening outcomes (Parker-Williams, 2021).

Moving Forward

As professional case managers, we are accountable for effectively moving our patients across the continuum of care. The Standards of Practice for Case Managers uses the following definition to describe our profession, "Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes" (Case Management Society of America, 2022).

The Case Management Model Act supports case management programs. This act also indicates that, as professional case managers, we have the specialized skills, knowledge, and competencies that lead to quality care and successful outcomes (Case Management Society of America, 2017). Isn't this the Triple Aim goal the path that healthcare needs to take? Regardless of our practice setting, if we each appropriately implemented a preventative screening question when communicating with our patients, imagine what type of outcome we could produce.

I challenge us as case managers to think outside the box and stretch a little further when communicating with our patients and their families. Consider the impact it can have on our profession. CE III

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PharmaFacts for Case Managers

Rolvedon™ (eflapegrastim-xnst) injection, for subcutaneous use

INDICATIONS AND USAGE

Rolvedon is indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.

Limitations of Use

Rolvedon is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

DOSAGE AND ADMINISTRATION

Recommended Dosage

The recommended dosage of Rolvedon is a single subcutaneous injection of 13.2 mg administered once per chemotherapy cycle. Administer approximately 24 hours after cytotoxic chemotherapy. Do not administer within the period from 14 days before to 24 hours after administration of cytotoxic chemotherapy.

Administration

Rolvedon is administered subcutaneously via a single-dose prefilled syringe by a healthcare professional.

DOSAGE FORMS AND STRENGTHS

Injection: 13.2 mg/0.6 mL as a clear, colorless, preservative-free solution in a single-dose prefilled syringe.

CONTRAINDICATIONS

Rolvedon is contraindicated in patients with a history of serious allergic reactions to eflapegrastim, pegfilgrastim, or filgrastim products. Reactions may include anaphylaxis.

WARNINGS AND PRECAUTIONS

Splenic Rupture

Splenic rupture, including fatal cases, can occur following the administration of recombinant human granulocyte colony-stimulating factor (rhG-CSF) products such as Rolvedon. Evaluate for an enlarged spleen or splenic rupture in patients who report left upper abdominal or shoulder pain after receiving Rolvedon.

Acute Respiratory Distress Syndrome

Acute respiratory distress syndrome (ARDS) can occur in patients receiving rhG-CSF products such as Rolvedon. Evaluate patients who develop fever and lung infiltrates or respiratory distress after receiving Rolvedon for ARDS. Discontinue Rolvedon in patients with ARDS.

Serious Allergic Reactions

Serious allergic reactions, including anaphylaxis, can occur in patients receiving rhG-CSF products such as Rolvedon. Permanently discontinue Rolvedon in patients with serious allergic reactions. Rolvedon is contraindicated in patients with a history of serious allergic reactions to eflapegrastim, pegfilgrastim, or filgrastim products.

Sickle Cell Crisis in Patients with Sickle Cell Disorders

Severe and sometimes fatal sickle cell crises can occur in patients with sickle cell disorders receiving rhG-CSF products such as Rolvedon. Discontinue Rolvedon if sickle cell crisis occurs.

Glomerulonephritis

Glomerulonephritis has occurred in patients receiving rhG-CSF products. The diagnoses were based upon azotemia, hematuria (microscopic and macroscopic), proteinuria, and renal biopsy. Generally, events of glomerulonephritis resolved after dose-reduction or discontinuation of rhG-CSF. If glomerulonephritis is suspected, evaluate for cause. If causality is likely, consider dose-reduction or interruption of Rolvedon.

Leukocytosis

White blood cell (WBC) counts of 100 x 109/L or greater have been observed in patients receiving rhG-CSF products. Monitor complete blood count during Rolvedon therapy. Discontinue Rolvedon treatment if WBC count of 100 x 109/L or greater occurs.

Thrombocytopenia

Thrombocytopenia has been reported in patients receiving rhG-CSF products. Monitor platelet counts.

Capillary Leak Syndrome

Capillary leak syndrome has been reported after administration of rhG-CSF products and is characterized by hypotension, hypoalbuminemia, edema, and hemoconcentration. Episodes vary in frequency and severity and may be life threatening if treatment is delayed. Patients who develop symptoms of cap-

illary leak syndrome should be closely monitored and receive standard symptomatic treatment, which may include a need for intensive care.

Potential for Tumor Growth Stimulatory Effects on Malignant Cells

The granulocyte colony-stimulating factor (G-CSF) receptor through which Rolvedon acts has been found on tumor cell lines. The possibility that Rolvedon acts as a growth factor for any tumor type, including myeloid malignancies and myelodysplasia, diseases for which Rolvedon is not approved, cannot be excluded.

Myelodysplastic Syndrome (MDS) and Acute Myeloid Leukemia (AML) in Patients with Breast and Lung Cancer

MDS and AML have been associated with the use of rhG-CSF products in conjunction with chemotherapy and/or radiotherapy in patients with breast and lung cancer. Monitor patients for signs and symptoms of MDS/AML in these settings.

Aortitis

Aortitis has been reported in patients receiving rhG-CSF products. It may occur as early as the first week after start of therapy. Manifestations may include generalized signs and symptoms such as fever, abdominal pain, malaise, back pain, and increased inflammatory markers (e.g., C-reactive protein and WBC count). Consider aortitis in patients who develop these signs and symptoms without known etiology. Discontinue Rolvedon if aortitis is suspected.

Nuclear Imaging

Increased hematopoietic activity of the bone marrow in response to growth factor therapy has been associated with transient positive bone imaging findings. This should be considered when interpreting bone imaging results.

Among patients receiving Rolvedon, a total of 272 patients received four 21-day treatment cycles. The most common adverse reactions (≥20%) were fatigue, nausea, diarrhea, bone pain, headache, pyrexia, anemia, rash, myalgia, arthralgia, and back pain.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no available data on Rolvedon use in pregnant women; however, data from published studies with use of other recombinant human granulocyte colony-stimulating factor (rhG-CSF) products in pregnant women have not identified any drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes.

Animal reproduction studies were conducted in rats and rabbits. In rats, eflapegrastim-xnst did not adversely affect embryofetal and/or postnatal development when administered from organogenesis throughout lactation at doses that produced maternal exposures up to 7 times the exposure at the recommended clinical dose. In rabbits, eflapegrastim-xnst caused embryofetal lethality and reduced fetal weight when administered during the organogenesis period at approximately 6 times the exposure at the clinical dose.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risks of major birth defects and miscarriage in clinically recognized pregnancies is 2%–4% and 15%–20%, respectively.

Lactation

Risk Summary

There are no data on the presence of eflapegrastim-xnst in human milk, the effects on the breastfed child, or the effects on milk production. Endogenous granulocyte colony-stimulating factor (G-CSF) is present in human milk. Other recombinant human granulocyte colony-stimulating factor (rhG-CSF) products are present in human milk at low levels and are not orally absorbed by infants. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Rolvedon and any potential adverse effects on the breastfed child from Rolvedon or from the underlying maternal condition.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

Of the 314 patients in clinical studies of Rolvedon, 39% were 65 and over, while 6% were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects.

OVERDOSAGE

Overdose of Rolvedon may result in leukocytosis and bone pain. In the event of overdose, general supportive measures should be instituted as necessary. Monitor the patient for adverse reactions.

CLINICAL STUDIES

Patients with Cancer Receiving Myelosuppressive Chemotherapy

The efficacy of Rolvedon to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs was evaluated in two 1:1 randomized, open-label, active-controlled non-inferiority studies of similar design (Study 1 [NCT02643420] and Study 2 [NCT02953340]) that enrolled a total of 643 patients with early-stage breast cancer. Docetaxel 75 mg/m^2 and cyclophosphamide 600 mg/m^2 (TC) were admin-

istered intravenously every 21 days (on Day 1 of each cycle) for up to 4 cycles. A fixed dose of Rolvedon 13.2 mg/0.6 mL or pegfilgrastim (6 mg/0.6 mL) was administered subcutaneously on Day 2 of each cycle after TC chemotherapy.

The median age of patients enrolled in the two randomized studies was 60 years (Range: 24 to 88), the majority of patients were female (>99%), 77% were White, and 12% were Black or African American.

Study 1 enrolled 406 patients; 196 patients to the Rolvedon arm and 210 patients to the pegfilgrastim arm. Study 2 enrolled 237 patients; 118 patients to the Rolvedon arm and 119 patients to the pegfilgrastim arm. Efficacy for both trials was based on the duration of severe neutropenia in Cycle 1.

In both studies, Rolvedon was non-inferior to pegfilgrastim.

HOW SUPPLIED/STORAGE AND HANDLING

Rolvedon (eflapegrastim-xnst) injection is a clear, colorless solution supplied in a single-dose prefilled syringe containing 13.2 mg of eflapegrastim-xnst in 0.6 mL solution, with 29-gauge 1/2 inch pre-attached (staked) needle with a needle guard.

Rolvedon is provided in a dispensing pack containing one sterile 13.2 mg/0.6 mL prefilled syringe (NDC 76961-101-01).

Store refrigerated at 36°F to 46°F (2°C to 8°C) in the carton to protect from light. Do not shake. Discard syringes stored at room temperature for more than 12 hours. Do not freeze; discard syringe if frozen.

For full prescribing information, see Product Insert.

Rolvedon is manufactured by Spectrum Pharmaceuticals, Inc.

Auvelity (dextromethorphan hydrobromide and bupropion hydrochloride) extended-release tablets, for oral use

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS

Antidepressants increased the risk of suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening and emergence of suicidal thoughts and behaviors. Auvelity is not approved for use in pediatric patients.

INDICATIONS AND USAGE

Auvelity is indicated for the treatment of major depressive disorder (MDD) in adults.

DOSAGE AND ADMINISTRATION

Important Recommendations Prior to Initiating and During Treatment with Auvelity

Prior to initiating and during treatment with Auvelity:

- Assess blood pressure and monitor periodically during treatment.
- Screen patients for a personal or family history of bipolar disorder, mania, or hypomania.
- Screen patients to determine if they are receiving any other medications that contain bupropion or dextromethorphan.

Recommended Dosage for Treatment of Major Depressive Disorder

The recommended starting dosage of Auvelity (45 mg of dextromethorphan hydrobromide and 105 mg of bupropion hydrochloride) is one tablet once daily in the morning. After 3 days, increase to the maximum recommended dosage of one tablet twice daily, given at least 8 hours apart. Do not exceed two doses within the same day.

Administer Auvelity orally with or without food. Swallow tablets whole, do not crush, divide, or chew.

Dosage Recommendations in Patients with Renal Impairment

The recommended dosage of Auvelity for patients with moderate renal impairment (eGFR 30 to 59 mL/minute/1.73 m^2) is one tablet once daily in the morning.

Dosage Recommendations for Concomitant Use with Strong CYP2D6 Inhibitors

The recommended dosage of Auvelity when coadministered with strong CYP2D6 inhibitors is one tablet once daily in the morning.

Dosage Recommendations for Known CYP2D6 Poor Metabolizers (PMs)

The recommended dosage for patients known to be poor CYP2D6 metabolizers is one tablet once daily in the morning.

Switching a Patient to or from a Monoamine Oxidase Inhibitor (MAOI) Antidepressant

At least 14 days must elapse between discontinuation of an MAOI intended to treat depression and initiation of therapy with Auvelity. Conversely, at least 14 days must be allowed after stopping Auvelity before starting an MAOI antidepressant.

DOSAGE FORMS AND STRENGTHS

Auvelity extended-release tablets contain 45 mg dextromethorphan hydrobromide and 105 mg bupropion hydrochloride. The tablets are beige and round with "45/105" debossed on one side.

CONTRAINDICATIONS

Auvelity is contraindicated in patients:

- with a seizure disorder
- with a current or prior diagnosis of bulimia or anorexia nervosa as a higher incidence of seizures was observed in such patients treated with the immediate-release formulation of bupropion

- undergoing abrupt discontinuation of alcohol, benzodiazepines, barbiturates, and antiepileptic drugs
- taking, or within 14 days of stopping, MAOIs due to the risk of serious and possibly fatal drug interactions, including hypertensive crisis and serotonin syndrome. Starting Auvelity in a patient treated with reversible MAOIs such as linezolid or intravenous methylene blue is contraindicated.
- with known hypersensitivity to bupropion, dextromethorphan, or other components of Auvelity. Anaphylactoid/anaphylactic reactions and Stevens-Johnson syndrome have been reported with bupropion. Arthralgia, myalgia, fever with rash, and other serum sickness-like symptoms suggestive of delayed hypersensitivity have also been reported with bupropion

Suicidal Thoughts and Behaviors in Adolescents and Young Adults

In pooled analyses of placebo-controlled trials of antidepressant drugs (selective serotonin reuptake inhibitors and other antidepressant classes) that included approximately 77,000 adult patients and 4,500 pediatric patients, the incidence of suicidal thoughts and behaviors in antidepressant-treated patients age 24 years and younger was greater than in placebo-treated patients. There was considerable variation in risk of suicidal thoughts and behaviors among drugs, but there was an increased risk identified in young patients for most drugs studied. There were differences in absolute risk of suicidal thoughts and behaviors across the different indications, with the highest incidence in patients with MDD.

It is unknown whether the risk of suicidal thoughts and behaviors in children, adolescents, and young adults extends to longer-term use, i.e., beyond 4 months. However, there is substantial evidence from placebo-controlled maintenance studies in adults with MDD that antidepressants delay the recurrence of depression and that depression itself is a risk factor for suicidal thoughts and behaviors.

Monitor all antidepressant-treated patients for any indication for clinical worsening and emergence of suicidal thoughts and behaviors, especially during the initial few months of drug therapy and at times of dosage changes. Counsel family members or caregivers of patients to monitor for changes in behavior and to alert the healthcare provider. Consider changing the therapeutic regimen, including possibly discontinuing Auvelity, in patients whose depression is persistently worse, or who are experiencing emergent suicidal thoughts or behaviors.

Seizure

Bupropion, a component of Auvelity, can cause seizure. The risk of seizure with bupropion is dose-related. When a bupropion hydrochloride (HCl) sustained-release tablet was dosed up to 300 mg per day (approximately 1.5 times the maximum recommended daily dosage of Auvelity), the incidence of seizure was approximately 0.1% (1/1,000) and increased to approximately 0.4% (4/1,000) at the maximum recommended dosage for the sustained-release tablet of 400 mg per day (approximately 2 times the maximum recommended daily dosage of Auvelity).

The risk of seizures is also related to patient factors, clinical situations, and concomitant medications that lower the seizure threshold. Consider these risks before initiating treatment with Auvelity. Auvelity is contraindicated in patients with a seizure disorder, current or prior diagnosis of anorexia nervosa or bulimia, or undergoing abrupt discontinuation of alcohol, benzodiazepines, barbiturates, and antiepileptic drugs. The following conditions can also increase the risk of seizure: severe head injury; arteriovenous malformation; CNS tumor or CNS infection; severe stroke; concomitant use of other medications that lower the seizure threshold (e.g., other bupropion products, antipsychotics, tricyclic antidepressants, theophylline, and systemic corticosteroids); metabolic disorders (e.g., hypoglycemia, hyponatremia, severe hepatic impairment, and hypoxia); use of illicit drugs (e.g., cocaine); or abuse or misuse of prescription drugs such as CNS stimulants. Additional predisposing conditions include diabetes mellitus treated with oral hypoglycemic drugs or insulin; use of anorectic drugs; and excessive use of alcohol, benzodiazepines, sedative/hypnotics, or opiates.

Because the risk of seizure with bupropion is dose-related, screen patients for use of other bupropion-containing products prior to initiating Auvelity. If concomitant use of Auvelity with other bupropion-containing products is clinically warranted, inform patients of the risk. Discontinue Auvelity and do not restart treatment if the patient experiences a seizure.

For other Warning and Precautions addressing increased blood pressure and hypertension, activation of mania and hypomania, psychosis and other neuropsychiatric reactions, angle-closure glaucoma, dizziness, serotonin syndrome and embryo-fetal toxicity, see full prescribing information in Product Insert.

USE IN SPECIFIC POPULATIONS

Pregnancy

Based on animal studies, Auvelity may cause fetal harm when administered during pregnancy. Auvelity is not recommended during pregnancy. If a female becomes pregnant while being treated with Auvelity, discontinue treatment and counsel the patient about the potential risk to a fetus.

Pediatric Use

The safety and effectiveness of Auvelity have not been established in pediatric patients.

continues on page 40

LitScan for Case Managers

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

AIDS. 2022 Sep 1.doi: 10.1097/QAD.0000000000003374. Online ahead of print.

Risk factors and prognostic significance of anemia in children with HIV infection on antiretroviral therapy

Lubega J, Grimes A, Airewele G, et al.

OBJECTIVES: To establish the incidence, risk factors and prognostic effect of anemia in children living with HIV (CLWH).

DESIGN: Retrospective nested case control study of patients 0-18 years in five centers in sub-Saharan Africa, 2004-2014.

METHODS: Incident cases of anemia were identified from electronic records and matched with CLWH without anemia. We calculated the incidence density of anemia and used conditional logistic regression to evaluate its association with risk factors, stratified by severity and type of anemia. We used a Cox proportional hazards model to evaluate the impact of anemia on survival.

RESULTS: 2,137 children were sampled. The incidence density of anemia was 1 per 6.6 CLWH-years. Anemia was moderate in 31.8% and severe in 17.3% of anemia cases, which had 10-year mortality hazards of 3.4 and 4.5, respectively. Microcytic anemia (36% cases) was associated with 2.3-fold hazard of 10-year mortality, and with malnutrition and CD4 suppression. Normocytic anemia (50.5% cases) was associated with 2.6-fold hazards of 10-year mortality, and with more severe malnutrition, CD4 suppression, and WHO stage, but inversely associated with Lamivudine and Nevirapine therapy. Macrocytic anemia (13.5% cases) was not associated with higher 10-year mortality nor with severe malnutrition or CD4 suppression, but was associated with WHO stage II/III and negatively associated with Lamivudine therapy.

CONCLUSIONS: This large multi-country study of CLWH found a high incidence density of anemia. Higher severity, normocytic and microcytic types of anemia were independently associated with long-term mortality. Laboratory studies are needed to decipher the mechanisms of anemia and how it impacts mortality in CLWH.

Clin Infect Dis. 2022 Sep 8;ciac739. doi: 10.1093/cid/ciac739. Online ahead of print.

Pregnancy status at the time of COVID-19 vaccination and incidence of SARS-CoV-2 infection

Magnus MC, Håberg SE, Carlsen EØ, et al.

BACKGROUND: Pregnant women are recommended to receive COVID-19 vaccines; however, relative effectiveness of vaccination by pregnancy status is unclear.

METHODS: We compared the relative effectiveness of mRNA COVID-19 vaccines according to whether women received both while pregnant (n= 7,412), one dose while pregnant (n = 3,538), both while postpartum (n = 1,856), or both doses while neither pregnant nor postpartum (n = 6,687). We estimated risk of SARS-CoV-2 infection starting 14 days after the second dose using Cox regression, reporting hazard ratios (HR) and 95% confidence intervals (CI). Secondly, we examined relative effectiveness of a third (booster) dose while pregnant compared to outside pregnancy. The major circulating variant during the study period was the Delta variant.

RESULTS: 54% of women received two doses of the BNT162b2 vaccine, 16% received two doses of the mRNA-1273 vaccine, while 30% received one dose of both vaccines. Compared to women who received both doses while neither pregnant nor postpartum, the adjusted HR for a positive SARS-CoV-2 PCR test was similar if the woman received both doses while pregnant (1.04; 95% CI: 0.94, 1.17), one dose while pregnant and one dose before or after pregnancy (1.03; 95% CI: 0.93, 1.14), or both doses while postpartum (0.99; 95% CI: 0.92, 1.07). The findings were similar for BNT162b2 (Pfizer-BioNTech Comirnaty) and mRNA-1273 (Moderna Spikevax), and during Delta- and Omicron-dominant periods. We observed no differences in the relative effectiveness of the booster dose according to pregnancy status.

CONCLUSIONS: We observed similar effectiveness of mRNA vaccines against SARS-CoV-2 infection among women regardless of pregnancy status at the time of vaccination.

Clin Infect Dis. 2022 Aug 31;75(3):525-533. doi: 10.1093/cid/ciab1069.

Tobacco use and treatment of tobacco dependence among people with human immunodeficiency virus: a practical guide for clinicians

Reddy KP, Kruse GR, Lee S, et al.

More than 40% of people with human immunodeficiency virus (PWH) in the United States smoke tobacco cigarettes. Among those on antiretroviral therapy, smoking decreases life expectancy more than human immunodeficiency virus (HIV) itself. Most PWH who smoke want to quit, but tobacco dependence treatment has not been widely integrated into HIV care. This article summarizes the epidemiology of tobacco use among PWH, health consequences of tobacco use and benefits of cessation in PWH, and studies of treatment for tobacco dependence among the general population and among PWH. We provide practical guidance for providers to treat tobacco dependence among PWH. A 3-step Ask-Advise-Connect framework includes asking about tobacco use routinely during clinical encounters, advising about tobacco cessation with emphasis on the benefits of cessation, and actively connecting patients to cessation treatments, including prescription of pharmacotherapy (preferably varenicline) and direct connection to behavioral interventions via telephone quitline or other means to increase the likelihood of a successful quit attempt.

JAMA. 2022 Sep 13;328(10):941-950. doi: 10.1001/jama.2022.15071.

Changes in health and quality of life in US skilled nursing facilities by COVID-19 exposure status in 2020

Barnett ML, Waken RJ, Zheng J, et al.

IMPORTANCE: During the COVID-19 pandemic, the US federal government required that skilled nursing facilities (SNFs) close to visitors and eliminate communal activities. Although these policies were intended to protect residents, they may have had unintended negative effects.

OBJECTIVE: To assess health outcomes among SNFs with and without known COVID-19 cases.

DESIGN, SETTING, AND PARTICIPANTS: This retrospective observational study used US Medicare claims and Minimum Data Set 3.0 for January through November in each year beginning in 2018 and ending in 2020 including 15 477 US SNFs with 2 985 864 resident-years.

EXPOSURES: January through November of calendar years 2018, 2019, and 2020. COVID-19 diagnoses were used to assign SNFs into 2 mutually exclusive groups with varying membership by month in 2020: active COVID-19 (≥1 COVID-19 diagnosis in the current or past month) or no-known COVID-19 (no observed diagnosis by that month).

MAIN OUTCOMES AND MEASURES: Monthly rates of mortality, hospitalization, emergency department (ED) visits, and monthly changes in activities of daily living (ADLs), body weight, and depressive symptoms. Each SNF in 2018 and 2019 served as its own control for 2020.

RESULTS: In 2018-2019, mean monthly mortality was 2.2%, hospitalization 3.0%, and ED visit rate 2.9% overall. In 2020, among active COVID-19 SNFs compared with their own 2018-2019 baseline, mortality increased by 1.60% (95% CI, 1.58% to 1.62%), hospitalizations decreased by 0.10% (95% CI, -0.12% to -0.09%), and ED visit rates decreased by 0.57% (95% CI, -0.59% to -0.55%). Among no-known COVID-19 SNFs, mortality decreased by 0.15% (95% CI, -0.16% to -0.13%), hospitalizations by 0.83% (95% CI, -0.85% to -0.81%), and ED visits by 0.79% (95% CI, -0.81% to -0.77%). All changes were statistically significant. In 2018-2019, across all SNFs, residents required assistance with an additional 0.89 ADLs between January and November, and lost 1.9 lb; 27.1% had worsened depressive symptoms. In 2020, residents in active COVID-19 SNFs required assistance with an additional 0.36 ADLs (95% CI, 0.34 to 0.38), lost 3.1 lb (95% CI, -3.2 to -3.0 lb) more weight, and were 4.4% (95% CI, 4.1% to 4.7%) more likely to have worsened depressive symptoms, all statistically significant changes. In 2020, residents in no-known COVID-19 SNFs had no significant change in ADLs (-0.06 [95% CI, -0.12 to 0.01]), but lost 1.8 lb (95% CI, -2.1 to -1.5 lb) more weight and were 3.2% more likely (95% CI, 2.3% to 4.1%) to have worsened depressive symptoms, both statistically significant changes.

Clin Infect Dis. 2022 Sep 1;ciac708. doi: 10.1093/cid/ciac708. Online ahead of print.

Liver inflammation is common and linked to metabolic derangements in persons with treated HIV

Chew KW, Wu K, Tassiopoulos K, et al.

BACKGROUND: We sought to characterize in people with HIV (PWH) the potential etiologies of elevated alanine aminotransferase (ALT) levels, which are common and often unexplained.

METHODS: Participants from the longitudinal observational AIDS Clinical Trials Group HAILO cohort without a history of hepatitis C virus (HCV) or hepatitis B virus (HBV) infection nor reported heavy alcohol use were included. Clinical and demographic

characteristics, including medication use, the Hepatic Steatosis Index (HSI), and metabolic syndrome (MetS) were compared between participants with and without ALT elevation.

RESULTS: Six hundred sixty-two participants were included; 444 (67%) had ≥1 and 229 (35%) ≥2 consecutive ALT elevations during a median of 4.0 years of follow-up. HSI and Hispanic or other (non-White or Black) race/ethnicity were consistently associated with higher odds of abnormal ALT (Odds Ratio, OR 1.1 for HSI as a continuous variable, OR 1.9-2.8 for Hispanic/other race/ethnicity for ≥1 or ≥2 ALT elevations); older age and current smoking were associated with lower odds of abnormal ALT. Associations with metabolic disease, as well as with incident HBV and HCV infection, were strengthened by restricting outcomes to persistent and higher degrees of ALT elevation.

CONCLUSIONS: ALT elevation was common in this cohort of PWH and associated with metabolic disease and hepatic steatosis markers. Nonalcoholic fatty liver disease is likely a common cause of liver inflammation in PWH receiving suppressive antiretrovirals, deserving targeted diagnosis and intervention.

Eur J Gastroenterol Hepatol. 2022 Oct 1;34(10):1098-1101. doi: 10.1097/MEG.0000000000002437. Epub 2022 Aug 24.

High sustained virologic response rate after 8 weeks of direct-acting antivirals in cancer patients with chronic hepatitis C virus

Yibirin M, Hosry J, Yepes Guevara Y, et al.

OBJECTIVE: There is no prospective data on 8 weeks of direct-acting antivirals (DAA) therapy with glecaprevir/pibrentasvir (GLE/PIB) or ledipasvir/sofosbuvir (LDV/SOF) in hepatitis C virus (HCV)-infected patients with different types of malignancies. This study evaluated the efficacy and safety with 8 weeks of DAA therapy in cancer patients with chronic HCV infection.

METHODS: Patients treated with DAAs at our center during 2014-2021 were included in a prospective observational study. Efficacy (sustained virologic response at 12 weeks; SVR12) and safety [adverse events and clinically significant drug-drug interactions (DDIs)] were assessed.

RESULTS: We included 47 patients. Most were men (29; 62%), white (33; 70%), non-cirrhotic (45; 96%), and with HCV genotype 1 (38; 85%). None of the patients had HCC. The SVR12 rate was 96% (45/47; 95% CI: 86-99%) for the entire study cohort, 100% [17/17; 95% CI: 82-100%] for the patients treated with GLE/PIB and 93% [28/30; 95% CI: 79-98%] for the patients treated with LDV/SOF. Fisher's exact test showed no significant difference in SVR12 rates between the regimens(P = 0.53). No patients had serious adverse events (grade 3-4) or treatment discontinuation. Among the 17 patients who received concomitant cancer therapy, no DDIs occurred.

CONCLUSION: Eight weeks of DAA therapy is highly effective and safe in HCV-infected patients with different types of malignancies and may grant access to investigational cancer therapy, broadening treatment options.

Am J Cardiol. 2022 Oct 1;180:81-90.doi: 10.1016/j.amjcard.2022.06.047. Epub 2022 Aug 6.

Relation of sociodemographic factors with primary cause of hospitalization among patients with left ventricular assist devices (from the National Inpatient Sample 2012 to 2017)

Cai J, Xia W, Greenberg P, et al.

Left ventricular assist devices (LVADs) are an established intervention for end-stage heart failure (HF). Rehospitalization for serious complications remains common during the continuous-flow LVAD era. Whether sociodemographic factors are associated with differences in the frequency of severe complications leading to hospitalization remains unclear. Using data from the National Inpatient Sample, we identified all hospitalizations from 2012 to 2017 of adults aged ≥18 years with previous LVAD placement. We categorized the primary cause of hospitalizations into key adverse diagnoses, including bleeding, HF, arrhythmias, LVAD complications, stroke, and a composite of device-related infection or sepsis. We assessed the association of sociodemographic markers with primary diagnoses using modified Poisson regression. We identified 62,630 hospitalizations during the study period (41% aged ≥65, 77% men, 26% Black, 5% Hispanic). Bleeding (18%), infections (15%), and HF (15%) were the most common primary diagnoses. In the multivariable analyses, gastrointestinal bleeding was more likely among older adults (relative risk [RR] 95% confidence interval [CI] 4.69 [3.57 to 6.16]; age ≥65 vs 18 to 44 years), among Black than White patients (RR 95% CI 1.17 [1.04 to 1.32]), and less likely for the highest income quartile than the lowest (RR 95% CI 0.79 [0.69 to 0.91]). Device-related infection/sepsis was also less likely for patients with higher income (RR 95% CI 0.80 [0.67 to 0.96]). Ventricular arrhythmias were less frequent diagnoses for women than men (RR 95% CI 0.59 [0.46 to 0.75]). LVADs complications were less likely in older adults than younger adults (RR 95% CI 0.70 [0.50 to 0.98]). In conclusion, after LVAD implantation, the frequency in which specific adverse events are the primary cause of rehospitalization varies significantly by sociodemographic factors. Further study is needed to determine if there are opportunities for targeted preventive measures based on sociodemographic markers.

Clin Transplant. 2022 Sep 8;e14819. doi: 10.1111/ctr.14819. Online ahead of print.

Long-term changes in body weight and serum cholesterol in heart transplant recipients

Miura K, Yu R, Entwistle TR, et al.

INTRODUCTION: Long-term changes in weight and blood lipids beyond 12 months after heart transplantation are largely unknown. We quantified changes in weight, body mass index (BMI), blood cholesterol and triglycerides in heart transplant recipients during the 36 months after transplantation, and we assessed the influence of statin therapy on these outcomes.

METHODS: Retrospective cohort study of adult heart transplant recipients, transplanted 1990-2017, in Queensland, Australia. From each patient's medical charts, we extracted weight, total cholesterol, triglycerides, and statin therapy at four time-points: time of transplant (baseline), and 12-, 24-, 36-months post-transplant. Changes in weight and blood lipids were assessed according to baseline BMI.

RESULTS: Among 316 heart transplant recipients, 236 (median age 52 years, 83% males) with available information were included. During the 36 months post-transplant, all patients gained weight (83.5 kg to 90.5 kg; p<0.001), especially those with baseline BMI <25.0 km/m 2 (67.9 kg to 76.2 kg; p<0.001). Mean blood cholesterol (4.60 to 4.90 mmol/L; p = 0.004) and mean blood triglycerides (1.79 to 2.18 mmol/L; p = 0.006) also increased significantly in all patients, particularly in those with baseline BMI ≥25.0 km/m2 but the differences were not significant (total cholesterol 4.42 to 5.13 mmol/L; triglycerides 1.76 to 2.47 mmol/L). Total cholesterol was highest in patients not taking statins, and levels differed significantly (p = 0.010) according to statin dosing changes during the 36 months post-transplant.

CONCLUSION: Patients demonstrate significant rises in weight and blood lipids in the 36 months after heart transplantation.

Am J Hypertens. 2022 Sep 1;35(9):810-819. doi: 10.1093/ajh/hpac082.

Home blood pressure compared with office blood pressure in relation to dysglycemia

Af Geijerstam P, Engvall J, Östgren CJ, et al.

BACKGROUND: Masked hypertension is more common in individuals with type 2 diabetes than in individuals with normoglycemia. We aimed to explore if there is a discrepancy between office blood pressure (office BP) and home blood pressure monitoring (HBPM) in relation to HbA1c as well as glycemic status in 5,029 middle-aged individuals.

METHODS: HBPM was measured in a subsample of 5,029 participants in The Swedish CardioPulmonary BioImage Study (SCAPIS), a population-based cohort of 50-64 years old participants. Both office BP and HBPM were obtained after 5 minutes' rest using the semiautomatic Omron M10-IT oscillometric device. White coat effect was calculated by subtracting systolic HBPM from systolic office BP. Participants were classified according to glycemic status: Normoglycemia, prediabetes, or diabetes based on fasting glucose, HbA1c value, and self-reported diabetes diagnosis.

RESULTS: Of the included 5,025 participants, 947 (18.8%) had sustained hypertension, 907 (18.0%) reported taking antihypertensive treatment, and 370 (7.4%) had diabetes mellitus. Both systolic office BP and HBPM increased according to worsened glycemic status (P for trend 0.002 and 0.002, respectively). Masked hypertension was more prevalent in participants with dysglycemia compared with normoglycemia (P = 0.036). The systolic white coat effect was reversely associated with HbA1c (P = 0.012).

CONCLUSIONS: The systolic white coat effect was reversely associated with HbA1c, and the prevalence of masked hypertension increased with dysglycemia.

Am J Kidney Dis. 2022 Sep 1;S0272-6386(22)00861-7. doi: 10.1053/j.ajkd.2022.07.008. Online ahead of print.

Supermarket proximity and risk of hypertension, diabetes, and CKD: a retrospective cohort study

Garg G, Tedla YG, Ghosh AS, et al.

RATIONALE & OBJECTIVE: Living in low-access food environments may increase the risk of chronic diseases. The objective of this study is to investigate the association between household's distance to the nearest supermarket as a measure of food access and incidence of hypertension, diabetes, and chronic kidney disease (CKD) in the Chicago metropolitan area.

STUDY DESIGN: Retrospective cohort study.

SETTING & PARTICIPANTS: 777,994 individuals without hypertension, diabetes, or CKD within the Health LNK Data Repository, which contains electronic health records from seven health care institutions in Chicago, Illinois.

EXPOSURE: Average household's distance to nearest supermarket in a zip code.

OUTCOMES: Incidence of hypertension, diabetes, and CKD based on presence of ICD-9 code and/or blood pressure ≥140/90 mm Hg, hemoglobin A1c≥6.5%, and eGFR<60 mL/minute/1.73m^2, respectively.

ANALYTICAL APPROACH: Average distance to nearest

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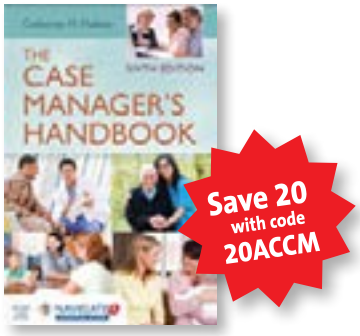

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"Painting a Picture" of the Patient for Auditors

continued from page 5

very skeptical of documentation that repeats itself throughout patients' medical records.

Auditors are especially likely to deny claims that include documentation that was obviously copied using the above functions, when the information copied "sticks out like a sore thumb." If hospice staff document, for example, that "the patient eats a lot of Mexican food" over and over in clinicians' visit notes, auditors are understandably skeptical about whether services were necessary for a hospice patient who seems to have a robust appetite or whether services were, in fact, rendered.

So, what does it mean to "paint a picture?" If a home health patient needs wound care or injections of medications, for example, the "picture" must account for why patients or their caregivers are not performing these activities themselves. Clinicians need to describe the following in a "picture" of the patient:

- Does the patient live alone or have caregivers?
- Why can't patients do wound care or self-inject medications?
- Why can't caregivers perform these activities?
- What attempts did clinicians make to assist patients and caregivers to provide wound care and injections?
- Why were these attempts unsuccessful?
- What attempts were made to find other caregivers—either paid or voluntary—who might provide these types of care?
- What were the results of these attempts to find other caregivers?

Despite the initial inability of patients and caregivers to render this care themselves, what efforts did clinicians make to help ensure that they became able to do so?

You get the picture! It's very difficult, if not impossible, to paint the above picture using only the boxes and blanks of forms in EMRs. More is needed if providers are serious about positive audit results. CM

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continued from page 16

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LITSCAN FOR CASE MANAGERS

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supermarket was aggregated from street-level metrics for 56 Chicagoland zip codes. The average incidence of hypertension, diabetes, and CKD from 2007-2012 was calculated for each zip code in patients free of these diseases in 2006. Spatial analysis of food access and disease incidence was performed using Bivariate Local Indicator of Spatial Association (BiLISA) maps and Bivariate Local Moran I statistics. The relationship between supermarket access and incidence of hypertension, diabetes, and CKD was determined using logistic regression.

RESULTS: Out of 777,994 participants, without hypertension, diabetes, or CKD at baseline (2006), 408,608 developed hypertension, 51,380 developed diabetes, and 56,365 developed CKD from 2007 to 2012. There was significant spatial overlap between average distance to supermarket and incidence of hypertension and diabetes but not CKD. Zip codes with large average supermarket distances and high incidence of hypertension and diabetes were clustered in southern and western neighborhoods. Models adjusted only for neighborhood factors (zip code level racial composition, vehicle access, median income) revealed significant associations between average zip code level distance to supermarket and incidence of hypertension [odds ratio(OR): Tertile 2 1.03 (1.02 - 1.05), Tertile 3 1.04 (1.02 - 1.06)] diabetes [Tertile 2 1.27 (1.23 - 1.30), Tertile 3 1.38 (1.33 - 1.43)], pre-diabetes [Tertile 2

continues on page 40

CE2

CE3

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Additional Resources

AARP https://www.aarp.org/caregiving/home-care/info-2017/adult-day-care.html

Alzheimer's Association https://www.alz.org/help-support/caregiving/care-options/adult-day-centers

ARCH National Respite Network & Resource Center https://archrespite.org/

CARF International www.carf.org/aging

Centers for Disease Control and Prevention (CDC) National Center for Health Statistics –National Post-acute and Long-term Care Study https://www.cdc.gov/nchs/npals/

Department of Veterans Affairs https://www.va.gov/geriatrics/pages/Adult_Day_Health_Care.asp

Eldercare Locator/Aging & Disability Resource Center network https://eldercare.acl.gov

Generations United www.gu.org

Genworth Cost of Care Survey https://www.genworth.com/aging-and-you/finances/cost-of-care.html

National Adult Day Services Association www.nadsa.org

Program for All-inclusive Care for the Elderly (PACE) www.npaonline.org

The Journey from Certificant to Volunteer to Commissioner

continued from page 7

My involvement in the disability management field expanded further in 2021, when I received an email from CCMC with a link to the application for nomination to become a CCMC Commissioner. Having been involved with CDMS for many years, I considered this to be the next logical step to pursue. I put forth my name and, at the CCMC annual meeting in mid-2022, I was elected to be a Commissioner, which is a volunteer position with an initial 4-year term.

As I embark on this next phase of my professional journey, I am excited to work with my fellow Commissioners to support the process of getting certified, staying certified, and developing others who pursue the Certified Case Manager (CCM) or CDMS certifications. As a Commissioner, I hope to deepen my knowledge even further into evidence-based best practices in case management and disability management. There is much change and growth in both fields in response to such trends as the aging of the population and greater integration of wellness and prevention into all aspects of health and human services.

Reflecting on my journey thus far, I can see how my desire to participate in and promote a professional community has helped advance my career. I encourage others to consider where they are on their own paths, as case managers, disability case managers, disability management specialists, or in other related roles. Professional certification attests to one's commitment to practice at the highest level.

Certificants can find ample opportunities to become involved as volunteers for committees, task forces, and boards. This is especially important for CDMSs who may be among a small group of disability management professionals in their workplace. By becoming involved in CDMS professional development opportunities, such as CCMC's Symposium, or as CDMS volunteers, they can access a much broader community and a wide variety of employers and employment settings. This exposure is more important than ever at a time of new developments from federal, state, and local regulatory changes to new paid and unpaid leaves offered by employers. As our field evolves, we must stay current. Getting involved helps ensure that we're part of the flow and exchange of information. CM

A Theoretical Grounding for Intensive Case Management

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that the client is certain to succeed or fail—our unconditional positive regard ignores all the capacities and inclinations of the client. Our favor toward the client does not depend on our trusting his or her ability to change. Beyond respecting the client's inherent value as a human, we pay no regard to what the client has or has not, is or is not, does or fails to do. The generosity of this attitude creates an environment conducive to change.

Measuring Change

Be careful not to measure your effectiveness as a care manager by one client's outcome. Reserving judgment on yourself will keep you sane and keep you from giving up on the client. I have seen many case managers give up on clients after some "failure" because they used a client's health choices to evaluate their own efficacy. When clients fail, case managers sometimes feel that they themselves have failed, so they give up on the client. But setbacks are to be expected.

For example, when beginning care with an alcoholic, sobriety should not be the case manager's first goal for the client. Rather, an open discussion of the client's alcohol abuse could be a great starting point. Expecting sobriety right away will overwhelm both the client and the case manager when relapses occur, but realistic goal setting helps both parties remain hopeful as they make slow progress.

Instead of hoping for overnight transformations, I work for advances in the stages of the Transtheoretical Model of Health Behavior Change, which describes the process by which people change their behavior. According to Prochaska and Velicer, the "Stages of Change" are as follows (Prochaska & Velicer, 1997):

- precontemplation, in which people do not intend to take action in the next 6 months;
- contemplation, in which people intend to take action in the next 6 months;
- preparation, in which people have a plan and intention to take action in the next month;
- action, in which people have changed their lifestyle in the last 6 months;
- and maintenance, in which people work to prevent regression in these stages but do not require the frequent and drastic changes of the action stage.

After months of work with a difficult client, he may continue to have unhealthy behaviors. But if he has identified his unhealthy behaviors and moved into contemplation, he and I have achieved something, and I can set my sights on the preparation stage.

Humble Resourcefulness

A word must be said in closing about the extent of our duties. We cannot provide care that exceeds our

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A New Commissioner Perspective: Embracing the Case Management Connection in Behavioral Health Counseling *continued from page 8*

Such exchanges not only build trust and rapport but also reflect case management values in action: supporting advocacy, promoting autonomy, and upholding justice and fairness.

Indeed, one of the most satisfying aspects of my job is helping people access the resources that they need. As I have found in my work, decreasing people's stressors by providing them with resources offers predictability and control in their lives and goes a long way to improving their mental health.

Becoming Involved with CCMC

Another component of my career development has been increasing my involvement with CCMC. In 2016, the Commission first reached out to me with a request to gain my perspective as a behavioral health professional and how that contributes to the wholeness of healthcare. Little did I know when I volunteered that this would require me to retake the CCM certification examination—not to get recertified but to validate test questions. However, I found it hugely gratifying to work with CCMs from varied professional backgrounds and care settings, all of us united to help advance and improve healthcare.

After that first activity, I said yes to every opportunity to volunteer with the Commission. And each time, I expanded my knowledge in some new area, particularly in clinical care, which differs from my daily job responsibilities.

My involvement with the Commission expanded further when, earlier this year, I was invited to apply to become a Commissioner. Admittedly, I was nervous at first since I am not an RN (which is the background of most, but certainly not all, CCMs today). However, others with mental health and counseling backgrounds have served as Commissioners, and I embrace the Commission's mission to increase diversity in all forms, both on the Commission and among certificants. My background with the U.S. Department of Defense and my perspective on people with military service and veterans also add to the varied experiences among Commissioners and the wide range of individuals and populations we serve.

Going forward, I am eager to engage in discussions with my fellow Commissioners on how we can advance the case management profession. As we look to the future, we know that the role of case managers will likely expand in every care setting and discipline, to help people identify and pursue their goals for better health, wellness, and quality of life. CM

A Theoretical Grounding for Intensive Case Management *continued from page 38*

qualifications, but we cannot limit ourselves to services that require licenses and certifications. I cannot belabor the finer points of cognitive behavioral therapy with a hungry client—I must go to the food pantry. CM

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CMSA Moving Forward: Strategic Plan Maps the Road to the Future! *continued from page 6*

sharing the progress and accomplishments made as a result of this plan over the next 3–5 years. CM

The Case Management Society of America (CMSA) facilitates the growth and development of professional case managers across the full health care continuum, promoting high quality, ethical practice benefitting patients and their families. We strive for improved health outcomes by providing evidence-based resources, impacting health care policy and sustaining the CMSA-developed Standards of Practice for Case Management. www.cmsa.org

The Queen's Leadership Lessons for Case Managers *continued from page 3*

advancement into a leadership position, the ability to communicate is essential. To that end, I invite you to contact me to explore submitting an article to *CareManagement*. You can do this!

Wishing you an enjoyable Fall as we make a difference—one patient at a time!!

Catherine M. Mullahy, RN, BS, CRRN, CCM, FCM, Executive Editor
cmullahy@academyccm.org

Readers

Have an idea for an article? Send your suggestions for editorial topics to: cmullahy@academyccm.org.

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Geriatric Use

Clinical studies with Auvelity did not include patients 65 years of age and older to determine whether they respond differently than younger adult patients.

Renal Impairment

Dosage adjustment of Auvelity is recommended in patients with moderate renal impairment (eGFR 30 to 59 mL/minute/1.73 m^2). The pharmacokinetics of Auvelity have not been evaluated in patients with severe renal impairment. Auvelity is not recommended in patients with severe renal impairment (eGFR 15 to 29 mL/minute/1.73 m^2).

CLINICAL STUDIES

The efficacy of Auvelity for the treatment of MDD in adults was demonstrated in a placebo-controlled clinical study (Study 1, NCT04019704) and confirmatory evidence which included a second study comparing Auvelity to bupropion hydrochloride sustained-release tablets (Study 2, NCT03595579). In Study 1, adult patients (18 to 65 years of age) who met the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for MDD were randomized to receive Auvelity (45 mg of dextromethorphan hydrobromide and 105 mg of bupropion hydrochloride) twice daily (N=156) or placebo twice daily (N=162) for 6 weeks. Patients in Study 1 had a median age of 41 years and were 67% female, 55% Caucasian, 35% Black, and 5% Asian.

The primary outcome measure was the change from baseline to Week 6 in the total score of the Montgomery-Asberg Depression Rating Scale (MADRS). The MADRS is a clinician-rated scale used to assess the severity of depressive symptoms. Patients are rated on 10 items to assess feelings of sadness, inner tension, reduced sleep or appetite, difficulty concentrating, lassitude, lack of interest, pessimism, and suicidality. Scores on the MADRS range from 0 to 60, with higher scores indicating more severe depression. Auvelity was statistically significantly superior to placebo in improvement of depressive symptoms as measured by decrease in MADRS total score at Week 6. The change in MADRS total score from baseline to Week 1 and from baseline to Week 2 were pre-specified secondary efficacy endpoints. The difference between Auvelity and placebo in change from baseline in MADRS total score was statistically significant at Week 1 and at Week 2. In Study 2, patients with MDD were randomized to receive Auvelity or bupropion hydrochloride sustained-release tablets 105 mg twice daily for 6 weeks. The primary outcome measure was calculated by assessing the change from baseline in total MADRS score at each on-site visit from Week 1 to Week 6 and then taking the average of those scores. The results of the study demonstrated that dextromethorphan contributes to the antidepressant properties of Auvelity.

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For full prescribing information, see Product Insert. Auvelity is distributed by Axsome Therapeutics, Inc.

LITSCAN FOR CASE MANAGERS

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1.51 (1.33 - 1.71), Tertile 3 1.78 (1.55 - 2.05)], and CKD [Tertile 2 1.18 (1.15 - 1.21), Tertile 3 1.33 (1.29- 1.37)]. Models adjusted only for demographic factors and health insurance showed significant and positive association with incident diabetes [Tertile 2: 1.29 (1.26 - 1.33), Tertile 3: 1.35 (1.31 - 1.39)] and pre-diabetes [Tertile 2: 1.33 (1.18 - 1.50), Tertile 3: 1.37 (1.21 - 1.55)] but negative association with hypertension [Tertile 2: 0.95 (0.94 - 0.97), Tertile 3: 0.91(0.89 - 0.92)] and CKD [Tertile 2: 0.80(0.78 - 0.82), Tertile 3: 0.73 (0.72 - 0.76)]. After adjusting for both neighborhood and individual covariates, the association remained significant and positive for diabetes and pre-diabetes, attenuated and became non-significant for CKD and was negative for hypertension.

LIMITATIONS: Unmeasured neighborhood and social confounding variables; zip-code level analysis; limited individual-level information.

CONCLUSIONS: There are significant disparities in supermarket proximity and incidence of hypertension, diabetes and CKD in Chicago, IL. The relationship between supermarket access and chronic disease is largely explained by individual and neighborhood-level factors.

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