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Gary S. Wolfe

Millennials and Health Care

The term *Millennials* is usually considered to apply to individuals who reached adulthood around the turn of the 21st century. The precise delineation varies from one source to another, however. Generally, Millennials were born between 1978 and 2000. Millennials, also known as Generation Y or the Net Generation, are the demographic cohort that directly follows Generation X.

Millennials grew up in an electronics filled and increasingly online and socially networked world. They are the generation that has received the most marketing attention. As the most ethnically diverse generation, Millennials tend to be tolerant of difference. Having been raised under the mantra "follow your dreams" and being told they were special, they tend to be confident. While largely a positive trait, the millennial generation's confidence has been argued to spill over into the realms of entitlement and narcissism. They are often seen as slightly more optimistic about the future of America than other generations—despite the fact that they are the first generation since the Silent Generation that is expected to be less economically successful than their parents.

Some statistics on Millennials:

- 50% percent of Millennials consider themselves politically unaffiliated
- 29% consider themselves religiously unaffiliated
- They have the highest average number of Facebook friends, with an average of 250 friends vs Generations X's 200
- 55% vs 20% of Generation X have posted a selfie or more to social media sites
- 8% of Millennials claim to have sexted, whereas 30% claim to have received sexts
- They send a median of 50 texts a day
- As of 2012, only 19% of Millennials said that, generally, others can be trusted
- There are about 76 million Millennials in the United States (based on research using the years 1978–2000)
- Millennials are the last generation born in the 20th century
- 20% have at least one immigrant parent

Millennials have emerged into adulthood with low levels of social trust. In response to a long-standing social science survey question, "Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people?" just 19% of Millennials say most people can be trusted, compared with 31% of Gen Xers, 37% of Silents, and 40% of Boomers.

Millennials are clearly different in workplace, technology and culture. The bring-your-own device trend (BYOD), for example, is at least in part a reaction to the Millennials' near-addiction to mobile devices. Workplace satisfaction matters more to Millennials than monetary compensation, and work-life balance is often considered essential. They are less likely than previous generations to put up with an unpleasant work environment and much more likely to use social networking to broadcast their concerns. Millennials grew up with computers, the Internet, and the graphical user interface (GUI). This familiarity makes them adept at understanding interfaces and visual languages. They tend to adjust readily to new programs, operating systems (OS), and devices and to perform computer-based tasks more quickly than older generations. Although it's been proven that multitasking is not usually an effective way to work, Millennials may be the employees that are most likely to pull it off. Millennials are generally comfortable with the idea of a public Internet life. Privacy, in the Millennial eye, is mostly a

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Win-Win Accommodations: Creating a Culture of Disability Acceptance in the Workplace

When an employee becomes disabled from a workplace injury, returning them to work as soon as medically feasible—within 90 days if possible—should be a priority for the employer, says Ryan Guppy, CDMS, chief of return-to-work partnerships for the Washington State Department of Labor and Industries. Increased productivity, better morale, reduced downtime, and lower workers' compensation rates are among the payoffs for employers, while workers benefit physically, psychologically, and financially from rejoining their colleagues on the job—in light-duty or transitional positions if necessary.

Similarly, employers can benefit from proactively hiring new employees with disabilities, says Brooke Allan-Davis, MEd CDMS, a vocational service specialist with Washington's Department of Labor and Industries, noting that many such individuals have exceptional perseverance, loyalty, and problem-solving skills.

But some employers are reluctant to take on or take back workers with physical or mental health challenges, fearing that accommodations will be costly, job performance will be substandard, and other employees will be resentful. To overcome this mindset, disability management and vocational rehabilitation specialists must convince employers of the value of employing people with disabilities, Allan-Davis says. Managers, in turn, need to foster a culture of disability acceptance in the workplace.

Many online resources are available to assist employers in creating an inclusive environment. In addition, Washington and some other states offer financial incentives to employers who bring back and accommodate workers injured on the job.

Educating Management

Only 19.4% of adults with disabilities participate in the U.S. labor force, according to the U.S. Department of Labor's Office of Disability Employment Policy. "The level of employment for persons with disabilities is just abysmal," Allan-Davis says.

When encouraging employers to hire workers with disabilities, Allan-Davis distinguishes between people with an invisible condition, such as a mental health disorder or chronic disease, and a visible challenge, such as using a wheelchair or hearing aids.

> **"When we're talking about people with invisible disabilities, most of the time it's a matter of convincing management that these individuals are just as capable, if not more capable, than other folks."**

"When we're talking about people with invisible disabilities, most of the time it's a matter of convincing management that these individuals are just as capable, if not more capable, than other folks," she says. "They are very willing to work hard and often just need private accommodations that other employees need not know about."

Such accommodations might include allowing an employee to take time off for periodic doctors' appointments or have a flexible schedule with a later start time. Someone with depression or posttraumatic stress disorder, for instance, might find it difficult to work in the early morning but be incredibly productive in the afternoon, at a time when most other employees are getting sleepy or habitually looking at the clock, Allan-Davis says.

To help managers identify the most appropriate modifications for a disabled worker, Allan-Davis consults the Job Accommodation Network, which allows users to search by disability. Searching "attention-deficit/hyperactivity disorder," for example, in the JAN database reveals that someone with ADHD might benefit from a noise-cancelling headset to reduce auditory distractions or from space enclosures (cubicle walls) to reduce visual distractions in an open-office environment. Why bother? Studies have shown that individuals with ADHD tend to be highly creative and energetic and can hyperfocus on what they find absorbing—prized traits in many occupations.

"I emphasize to employers that individuals with disabilities have unique characteristics that set them apart from other people," Allan-Davis says. "They look at the world in a different way." As she tells employers, these workers often have stand-out traits such as patience, resilience, and gratitude for having a job.

When an employee with an overt disability is brought into the workplace, managers should prepare workers on how to make that individual feel comfortable and welcomed, states the United Spinal Association's free

online guide *Disability Etiquette: Tips on Interacting with People with Disabilities.* The booklet, which covers many different types of disabilities, can be used as the basis for informal training sessions. Among other insights, the guide warns, "Don't push or touch a person's wheelchair; it's part of [his or] her personal space." Also, "when talking to a person using a wheelchair, grab your own chair and sit at [his or] her level."

Return-to-Work Adaptations

When a worker has acquired a disability through an injury sustained on the job, other factors come into play when persuading an employer to accommodate that individual. Depending on the nature of the injury, a workers' compensation claim may fuel mistrust, fear, and resentment on the part of both employer and employee. Bringing the employee back to work as soon as possible—while the worker is healing and going through physical therapy, for example—can help defuse such emotions.

"If we don't intervene early enough in the process, there typically is an amount of animosity that builds up between the injured worker and the employer, which makes return to work more difficult," Guppy says.

Through its Stay at Work Program, the state of Washington offers a number of financial incentives to employers that welcome back injured workers who have not completely healed and cannot perform their previous jobs in the same way. If an employee is brought back to do light-duty or transitional work, the state will pay the employer 50% of that worker's regular wages up to $10,000. In addition, employers are eligible for reimbursement of up to $2,500 for tools and equipment needed to accommodate the injured worker and up to $500 in retraining costs.

"We have reimbursed 3,900 employers since we started the program in 2012," Guppy says. "And we have assisted almost 15,000 injured workers in getting back to light-duty work."

Early return-to-work programs benefit employers and employees in many ways, Guppy says. Employers regain experienced workers, who increase productivity and revenue. Workers' comp premiums don't rise as steeply. And employees heal faster and better when they're not sitting at home watching television all day.

Allan-Davis can cite many return-to-work success stories in her state, such as a long-term employee who lost his foot in a machinery accident who came back as a foreman and trained other workers to do his former job, as well as a truck driver with severe back problems who retrained as a dispatcher.

Some employers' hesitation to embrace people with disabilities can be attributed to fear of the unknown, she says. "We are afraid of what we don't know. We are afraid of what we haven't interacted with before."

Establishing a culture of disability acceptance "must come from the top down," Allan-Davis emphasizes. "Managers need to say, 'Hey, this is good for everyone.' They need to be cheerleaders." CM

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The Care Coordination Solution to the Health Care Challenge

By Patrice V. Sminkey, RN, *CEO, Commission for Case Manager Certification*

With millions of previously uninsured people now accessing health care coverage, the challenge is how these and other individuals will receive the right care and treatment at the right time, and in the most cost-effective way. The answer is care coordination—a proven, effective solution to achieving these outcomes.

More than ever, care coordination, which is integral to the case management process, will be the solution to today's most pressing health care challenges, such as complex cases. For example, the frail elderly population includes the most significant consumers of health resources, in both acute-care and community settings, who are also at risk for negative outcomes. Similarly, individuals with complex cases (i.e. two or more co-morbidities) require comprehensive care delivery to address the needs of the whole person, instead of taking an episodic approach in response to the onset of a new health problem or flare-up of a preexisting condition.

Add to that pay-for-performance within health care delivery today, affecting reimbursement to providers by private payers as well as the Centers for Medicare and Medicaid Services (CMS). This financial impact on hospitals, sub-acute facilities, primary practices, and other care settings raises the bar for coordinating care to elevate quality, achieve targeted outcomes, and improve efficiency and cost-effectiveness—all aligned with the goals and objectives of the Affordable Care Act (ACA).

The role of case managers, especially those who are board certified, continues to evolve in the post-ACA era, with greater expectations being placed on measurement and evaluation of quality and outcomes.

As the Commission for Case Manager Certification has identified in its latest field research (known as the Case Management Role and Function Study), case managers today are playing leading roles in the rapidly changing health care environment, particularly in care coordination and delivering competent case management.

The role of case managers, especially those who are board certified, continues to evolve in the post-ACA era, with greater expectations being placed on measurement and evaluation of quality and outcomes. The findings of the Case Management Role and Function Study demonstrated how case managers are being tasked with quality and outcomes not only for case management interventions, but also for care provided by interdisciplinary teams. In fact, quality and outcomes are so important, they are considered an "essential activity" of case management, according to the Commission for Case Manager Certification, which administers board certification. (To date, since 1992 and the inception of CCMC, more than 60,000 case managers have been board certified as Certified Case Managers, and nearly 40,000 CCMs are currently in practice.)

Importantly, case management and its care coordination component are practiced across the health care spectrum: acute care, subacute/rehabilitation, primary care (including accountable care organizations and patient-centered medical homes), community-based organizations, and in specialty areas such as vocational rehabilitation and workers' compensation. This breadth of practice speaks to the whole-patient focus of case management and care coordination. Case managers support the pursuit of desired outcomes such as reducing avoidable hospital readmissions and emergency room visits, as well as improving self-care.

All of us must build on the goals of the ACA to achieve patient-centered outcomes of better care, lower cost, and improved health for all. Meeting this challenge will require comprehensive solutions, starting with care coordination and case management, especially for those who stand the benefit the most from these services. CM

Patrice V. Sminkey, RN, *is CEO of the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies case managers. To date, more than 60,000 case managers have been certified, and currently more than 40,000 case managers are board certified as Certified Case Managers.*

More Proposed Changes in Discharge Planning for Critical Access Hospitals

By Elizabeth Hogue, Esq.

On November 3, 2015, the Centers for Medicare & Medicaid Services (CMS) published proposed regulations governing discharge planning by hospitals in the Federal Register. If finalized, these proposed regulations will require critical access hospitals (CAHs) to devote considerably more time and resources to discharge planning activities. Comments to these proposed regulations are due 60 days from the date of publication in the Federal Register.

If proposed regulations are finalized as drafted, CAHs will be required to meet specific requirements regarding discharge planning described below, in addition to the requirements summarized in Part 5 of this article series.

CAHs will be required to provide discharge instructions at the time of discharge to:

- Patients and/or patients' caregiver/support persons
- Post-acute care service providers or suppliers, if patients are referred to community-based services

Discharge instructions provided by CAHs must include, but are not necessarily limited to, the following:

- Instructions on post-discharge care to be used by patients or their caregivers/support person(s) in patients' homes, as identified in discharge plans
- Written information on warning signs and symptoms that may indicate the need for immediate medical attention. This information must include written instructions on what patients or caregiver(s)/support person(s) should do and who they should contact if warning signs or symptoms are present
- Prescriptions for medications that are required after discharge, including a list of names, indications and dosages of each drug along with any significant risks and side effects of each drug as appropriate to each patient

If finalized, these CMS proposed regulations will require critical access hospitals (CAHs) to devote considerably more time and resources to discharge planning activities.

- Reconciliation of all discharge medications with patients' pre-CAH admission/registration medications, both prescribed and over-the-counter
- Written instructions regarding patients' follow-up care, appointments, pending and/or planned diagnostic tests and pertinent contact information, including telephone numbers, for practitioners involved in follow-up care for any providers/suppliers to whom patients have been referred for follow-up care

CAHs will also be required to send the following information to practitioners responsible for follow up care:

- Copies of discharge instructions and discharge summaries within 48 hours of patients' discharges
- Pending test results within 24 hours of their availability
- CAHs will also be required to establish a post-discharge follow-up process.
- When patients are transferred from CAHs to other health care facilities, CAHs will be required to send necessary medical information to receiving facilities at the time of transfer. Necessary medical information includes:Demographic information, including but not limited to, name, sex, date of birth, race, ethnicity, and preferred language
- Contact information for the practitioner responsible for the care of patients
- Advance directive, if any
- Course of illness/treatment
- Procedures
- Diagnoses
- Laboratory tests and results of pertinent laboratory and other diagnostic testing
- Consultation results
- Functional status assessment
- Psychosocial assessments, including cognitive status
- Social supports
- Behavioral health issues
- Reconciliation of all discharge medications with patients' pre-CAH admission/registration medications both prescribed and over-the-counter
- All known allergies, including allergies to medications
- Immunizations

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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.*

CE 1

Trends in Case Management Acuity Determination

By Barbara Mawn

The purpose of this article is to examine the concept of case management acuity in the private sector and health insurance industry. In the era of the Affordable Care Act, case management practices across many sectors in the healthcare system are in a state of flux. In order to understand the context of current practices, a brief review of the various dimensions and definitions related to case management is presented. The concept of acuity will be defined and relevant trends in predictive modeling examined. The discussion section will integrate the findings from the literature as well as current and evolving practices in the health insurance sector.

Case Management

Overview

The concept of case management originally evolved in the early 1800s when public health nurses and social workers reached out to vulnerable populations through charitable organizations. Numerous governmental sponsored case management programs emerged after the passage of the Social Security Act of 1932, targeting the elderly, children, the unemployed and the blind. Insurance companies started to incorporate case management strategies after World War II to control the high medical costs of returning soldiers.[1] Since that time, the term has been defined inconsistently and has been "misused as a blanket term for medical management."[1] Today, there is still no standard definition.[2] Case management definitions and models vary by the setting (eg, primary care, hospital, insurer), the identified outcomes, and the discipline providing the service (eg, nursing, social work, medicine, or lay-worker).

Most definitions of case management include the various roles that are integral to the process: assessment, planning, linkage, monitoring, advocacy and outreach.[3] The Case Management Society of America first published its definition of the concept in 1995. The most recent version defines case management as "a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes."[4]

The term case management is often used interchangeably with care management or complex care management. However, Kathol et al. referred to case management and disease management as 2 examples from 7 types of care management.[5] The literature generally agrees that there is a distinction between case/care management and utilization management/review.[6] Kathol et al. note that while "there is always some utilization management activity associated with most forms of care management it is not the primary focus of care [case] managers.[5] Utilization managers primarily deal with providers and other service providers vs. helping clients to overcome barriers. They "manage claims" instead of clients on an individual level. Disease management differs from case management according to this source as it focuses on education and prevention of progression for specific diseases. Case managers work with all chronic diseases and other complex medical conditions to improve overall health and prevent complications. Case managers typically work with the 2% to 5% of the population who use 30% to 50% of health care resources.[6]

During the past decade, various "types" and "models" of case management have evolved, with none being considered the standard. Indeed there are currently 6 different accrediting agencies for case managers and 21 different certifications related to case management.[1] Descriptive terms such as "integrated case management"; "partially integrated case management"; "embedded case management" and "relational approach to care management" have added to the confusion. Cesta noted that the earlier traditional model of case management included

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two silos: utilization review and discharge planning, with each performed by different professionals from different departments.[7] She suggested that there are now three potential case management hospital models:

1. The partially integrated model (a dyad of RN and social worker roles)
2. The integrated model (all medical and social functions performed by same case manager)
3. The triad/collaborative model (separate roles or nurse medical manager, social service worker and utilization review manager)

Various role designations and interpretations of the role vary depending on the setting outside the hospital as well. Case management has moved well beyond the hospital borders since the 1960s.[1] It is now performed by large insurers, third party administrators, independent case management companies, community home health and residential programs, to name a few.[8] Thus there may be more than one case manager from more than one sector of the healthcare system providing 'case management' at any given time. How does the potentially wide range of case managers coordinate and manage care? Each may have access to different data sources as well as have different definitions of case management and varied outcomes.

Stafford and Berra have suggested that the critical element of success of any case management program is to recognize the system's culture and expectations of outcomes.[9] Thus case managers, who are operating within the culture of an insurer, may need to let go of the fully integrated model which allows managers to assess and assist with biological, psychological, social and healthcare access issues while maintaining a close personal connection over time with the client.[5] As Stafford and Berra[9] note, clear expectations relevant to the case management program outcomes are essential. Similarly, clear communication and delegation of roles among various case managers acting on behalf of the same client within the health care system are required to achieve quality, cost-effective health care.

In the past decade, the literature has identified a new trend in case management, the integration of information technology. These technologies include predictive modeling; evidence-based medicine tracking and electronic medical records.[10] Predictive modeling analyzes data from health insurance claims, health risk assessments, and/or pharmacy utilization to predict risks in the future.[11] Meek identified that the goal of predictive modeling is "to identify at-risk individuals for an undesired outcome for the purpose of intervening with them before the occurrence of adverse events."[12] It is often used as one of several techniques to identify members of a group who might benefit from case or disease management. The risk score generated from this type of program may also be used to prioritize levels of care.

Evidenced-based medicine tracking refers to the use of large claims' data sets to compare an individual's claims with population based trends related to accepted guidelines for care, such as cancer screening behaviors. In the insurance world, most claims' software and predictive modeling programs also allow for the creation of an electronic medical record based on claims data. These may or may not be linked to the actual client medical record at the primary care site. According to a URAC Survey, few information technology systems have a seamless platform accessible to clinicians as well as case managers from the insurer side.[11] The movement toward Accountable Care Organizational Models, as defined in the Affordable Care Act will help to drive the necessary changes needed to link the various players and data involved in case management.[12]

Acuity

Given the varying definitions and role expectations associated with case management, it is not surprising that there are also no commonly accepted standards to define and measure acuity of cases. Brennan and Daly published a concept analysis of the term "patient acuity" in an attempt to clarify this confusion.[13] They distinguished between non-patient-related (eg, sharpness/keen sensation), patient-related, provider-related, and systems-related acuity. The identified attributes related to patient-related acuity included onset, time-sensitivity and severity of illness. The provider-related attribute was defined in relation to intensity of health care services required. Three sub-categories were: nursing care needs, workload and complexity. System-related acuity included sub-categories of case-mix, patient classifications systems and urgency/triage scales. Of interest was their statement that the relationship between severity and intensity attributes of acuity may or may not be linear. They concluded that there is a great need for patient acuity scales that are validated and reliable.

Huber and Craig defined acuity as "the severity of illness or client condition that indicates the need for the intensity of the subsequent CM intervention."[3] They also identified three primary domains related to the concept: client need severity, CM intervention-intensity, and healthcare service delivery responsiveness. They developed the CM Acuity Tool that measures three levels of indicators related to clinical nursing, psychosocial caregivers, quality, and cost. In addition they defined "sub drivers" that further help to define the complexity of a case. They used a 4-point ranking scale for these

Given the varying definitions and role expectations associated with case management, it is not surprising that there are also no commonly accepted standards to define and measure acuity of cases.

indicators of complexity (1=low; 2=mild; 3=moderate; 4=severe). The scoring for each case allowed the development of a Caseload Matrix score to evaluate and compare complexity/intensity/acuity of caseloads. A second related tool developed by Huber and Craig also allows for an evaluation of acuity change scores over time, which could indicate the impact of a CM program.[3]

Another acuity tool for case management reported in the literature is the BluCuity Scale, developed for Blue Cross Blue Shield (BCBS) of Massachusetts by the original developers of the previously described CM Acuity Tool. This customized tool assesses three domains: client need/severity; primary and back-up caregiver need/severity; and CM intervention intensity.[14] Prior to the development of this tool, CM nurses at BCBS had to subjectively assess acuity into three rankings: low, medium and high. Once the new acuity tool was implemented, CM nurses had a 5-day period to complete an acuity assessment and determine acuity scores based on member assessments (using phone and other health data). The tool was tested for its reliability and validity in relation to case acuity, caseload acuity and acuity-based decision making with good results in 2008–2009. It was built into the information technology infrastructure and the electronic medical records system and remains in use today (personal communication, Kathy Craig, 7/6/13).

Three brief qualitative case studies of three agencies that provide care management services will be presented next. The first is a large insurer (Company A) that provides case and disease management services by its own nursing staff. Company B and Company C is both care management/disease management companies that provide services through insurers and directly to corporate clients. As expected, the working definitions and expected outcomes of care/care management differ among the agencies.

Case Study A

This company is a large insurer that uses the term care management for what others call [complex] case management. They distinguish this from disease management, which is where most of their employed nurses are spending their time. The major focus of their care coordination is on post-hospitalization care coordination and prevention of future hospitalizations. Their system generates referrals for evaluation based on high claim costs, hospitalizations for selected diagnoses, physician or member referral. The acuity definitions for both care management and disease management focus on the anticipated "intensity" of nursing interventions required to avoid a future hospitalization vs. the actual level of disease severity or client/caregiver psychosocial needs.

Care management in this company has relatively short term objectives, with approximately half of the care management cases "one [point of care coordination] and done". There are slight variations depending on some conditions, for example the frequency contact for the various acuity levels differs for high risk pregnancy vs. oncology members vs. members with a list of other selected chronic diseases. The current acuity levels are 1 to 5 with 1 requiring the highest levels of intervention/acuity (nurse contact once every 1–2 weeks) vs the lowest level of 5 (nurse contact at 10–12 weeks postdischarge for most chronic diseases; or at 3–6 weeks for postpartum cases). They also have a "0" classification for those not yet assigned. A revised 4-point acuity scale is currently underway. Nurses determine the acuity level; it is not automatically generated by any data in the system. The nurses determine the acuity after their initial assessment contact with the member and it can be changed after each contact if they have moved to another level.

Case Study B

Similarly, Company B, a national disease management company has a 5 point acuity rating scale that is also determined by the assigned nurse case manager. This is also based on anticipated nurse intensity but in contrast to Company A, their "1" is the lowest level of nursing contact (every 3–4 weeks) vs level "5" (telephonic contact every week). The nurse disease manager also determines the acuity within 24 hours after meaningful contact and assessment has been completed. Not surprisingly, with the emphasis on disease management, the focus of the program would be different. While hospital prevention is a key goal, education and achieving maximum wellness are also key objectives. This company uses an actual acuity tool that was

recommended by a consultant which they also individualized to their program's needs and objectives. Caseloads are assigned based on nurses' acuity caseload scores. The acuity score is also reported on a regular basis to clients. Changes in acuity scores are also potentially analyzed for members receiving long term disease management. The scoring remains the same regardless of the diagnosis in this company; each acuity score reflects the standard expected contact times anticipated by the nurse case manager.

Case Study C

In contrast to Companies A and B, Company C, a disease management company, uses three levels of acuity which are generated by an automated internal system. The system initially generates an acuity score with 3 levels: 1=high acuity; 2=moderate acuity; and 3=low acuity based on a predictive modeling program that determines the likelihood of inpatient admission and emergency room admission in the next six months to help determine the acuity. The nurses can adjust the acuity score after their assessments and interventions at any point. The high acuity is defined as an assessment call in addition to a minimum of 6 nurse interaction calls. The moderate level entails an assessment call and a minimum of 3 nurse interaction calls. The low acuity score are members with stable chronic conditions with no recent hospitalization who will receive education and monthly monitoring but no minimum calls. They utilize a proprietary analytic system to generate the risk scores based on diagnosis, health care gaps and medication/ pharmacy-based data. In contrast to the other disease management company, Company C does not use the acuity score to manage caseload assignments. They also do not use the same acuity scores generally for reporting to their clients. Instead, they report on level of engagement which has different definitions than their internally used acuity score.

Predictive Modeling

The logic in predictive modeling has been used in other CM acuity tools as described in the literature and Case Study A. The Verisk Health System is one of several predictive modeling programs available in the market today. A brief summary of each measure of risk identifiable through this program will be described as an exemplar for predictive modeling in order to determine the potential application of predictive modeling in case management.

The Risk Index (RI) is a representation of the frequency of occurrences of certain risk-predictive events based on an individual member's claims. Values and weights are assigned to selected diagnoses, procedures or drugs. Comorbidities are accounted for in the scoring system as well as disease specific criteria and treatment patterns. The Adjusted Risk Index (ARI) adjusts for treatment gaps and possible noncompliance. If the ARI is close to the RI then it reflects that the clinical treatment is adequate and the member is compliant. Both Risk Indexes identify those members who will incur significant medical costs and have a high level of clinical risk. The recommended values for risk ranges in the RI and ARI "bucket" are noted in Table 1.

The Care Gap Index (CGI) is analytic measurement incorporates the differences between the Risk Index and the Adjusted Risk Index. It is a more concrete evaluation of the members who are most out of sync with good medical care and compliance. It is recommended to be used as a clinical triggering mechanism to identify those who are most likely to improve with interventions. Thus a member may have a high RI and thus high cost claims are expected, however if the CGI is low, then it means that intervention may not make a difference, the member is getting adequate care. Table 1 also notes the numerical values assigned to the CGI. Of note, the there are different ranges with the CGI in comparison to the RI and ARI.

The Relative Risk Score is another analytic tool available through the Verisk Health system. This concept is based on diagnoses. It predicts future (12 months) claims costs based on an insurer's or company's book of business or Verisk national norms data. This helps to explain resource use and population-based clinical outcomes vs. individual clinical outcomes (covered by RI, ARI and CGI). The norm is the number 1. So if one has diabetes and has a RRS of 1, then his/her costs are predicted to be on par with the average person with diabetes. The number cannot be less than 0 but can be a zero or decimal point which suggests less than average future predicted costs. Thus a RRS of 2 would mean that the costs are predicted to be twice as high as the average person with that diagnosis. The analytic process adjusts for more than one diagnosis as well. The database also generates projected costs for next 12 months which can be documented

TABLE 1 COMPARISON OF VALUES FOR RISK ASSIGNMENT FOR RI, ARI, AND CGI

	RI Values	ARI Values	CGI Values
Low Risk	≤8	≤8	≤3
Medium Risk	9-20	9-20	4-5
High Risk	>20	>20	>5

ARI=Adjusted Risk Index; CGI=Care Gap Index; RI=Risk Index

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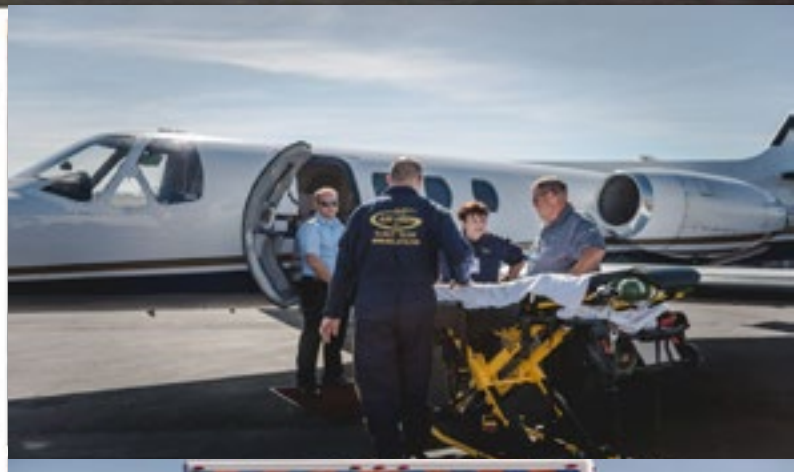

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The focus of case managers from the insurer side should be the reduction of claims costs and particularly, the prevention of rehospitalization.

and then compared to actual costs 12 months later to demonstrate return on investment from case management in some cases.

Discussion

Case management acuity is defined and used quite differently within the reported literature as well as in the three reported case study examples. Not surprisingly, the goals of case management also differ in various sectors of the health care system thus accounting for some of these differences. But even within similar segments of the health system, variation has flourished and continues to do so at this time.

Numerous challenges have impeded the standardization of how the concepts of case management and acuity are operationalized in the health insurance industry. With the Accountable Care Organization "train' approaching the system, the impact on case management at various intersections of health care case management remains unknown. In addition, the impact of evolving technology remains unclear. While some systems have already automated the generation of an acuity score, others have stayed with an original nurse designation. While some companies are currently using acuity scores for managing caseloads and assigning new cases, others are not there yet. The potential use of predictive risk modeling for case management case identification and acuity designation has not yet been realized. Various proprietary programs have their own unique formulas and definition of risk which precludes industry-wide standardization or risk.

Cesta reminds us that a major objective of case management should be to reduce and prevent future hospitalizations, regardless of where this service is provided (hospital, insurer, case management company etc) or who provides it.[5] Her review of the literature revealed 4 top reasons for hospital readmissions: not seeing the physician within ten days of initial discharge; not adhering to medication recommendations; lack of knowledge about disease management; and lack of home care post discharge. These are all potentially impacted by case management interventions and they are all potentially identified by the concept of the Care Gap Index as defined by Verisk Health.

With the focus on reducing hospitalizations and high claim costs from the insurer perspective, case managers from this sector need to focus on the deliverables. Acuity needs to be defined and parameters set to capture the minimum levels of intervention while meeting measurable objectives. As Kathol, Perez and Cohen state in The Integrated Case Management Manual (2010), "identified complexity [acuity] immediately translates into actionable steps mutually taken by the case manager and patient to improve health."[5]

There is no consensus on the determination of case complexity/ acuity/ intensity. Larger, more complex companies have reported in the literature the utilization of many facets of the term acuity to determine a score. However, the focus on nursing intervention levels as the key factor in determining acuity seems to be a common thread in many case management programs. However, the measure of the level of nursing intervention varied by nursing hours, number of contacts, and number of calls. It appears evident from the literature and the cases reviewed that buy-in from the case managers themselves and a nimble program that can allow for changes over time is critical. It has not been validated whether three vs. four or five levels of acuity are more appropriate; this review suggested that 4 to 5 levels are more common.

The focus of case managers from the insurer side should be the reduction of claims costs and particularly, the prevention of rehospitalization. The numbers alone suggest that there are constraints in terms of nursing staffing to handle all high cost cases and/or all members with high Care Gap Index levels. Those determined to be actionable and have a return on investment should remain the focus of case management from the insurer's perspective. The measure of acuity of CM cases needs to have buy-in from the ground up in the organization. The simplest and most clearly defined acuity definition based on minimum contacts may be more easily integrated vs determining the anticipated number of contact hours. Using a 4 or 5 point acuity scale may also be more helpful than a three level model so that the contact frequency can be clearly delineated.

Conclusion and Recommendations

Although the literature has revealed one reported reliable CM acuity tool, there are no standardized, consistent measures of CM acuity. The tool that

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CE II

The Millennial Patient: Transforming Health Care

By Catherine M. Mullahy, RN, BS, CRRN, CCM

If you look at health care today, you might well want to borrow the phrase Dorothy in the Wizard of Oz used when she realized she was no longer on familiar turf. That is, "Toto, I have a feeling we're not in Kansas anymore." The landscape in health care has changed dramatically over the past few years. One of the most transformative forces has been, and continues to be, millennials, those individuals aged 18 to 34 in 2015. Estimated to be 75.3 million strong by the US Census Bureau, they are introducing a whole new set of demands and challenges to healthcare providers and professionals, including case managers. They communicate differently and expect their preferred forms of communications to be accommodated. They are extremely cost-conscious, and have different healthcare sensibilities and behaviors. It's important to understand the nuances of this group so that millennial patients can be provided the best level of care in the manner in which it is most meaningful to them.

Catherine M. Mullahy, RN, BS, CRRN, CCM *is President of Mullahy & Associates, LLC, (Huntington, NY, www.mullahyassociates.com) a leading national educational and training organization and designated educational partner by the Commission for Case Manager Certification (CCMC) for the CCM Certification Preparation Workshop. Mullahy is a widely-respected case management pioneer and thought leader. She has been integrally involved in the development of professional standards and certification for case managers and was a member of the initial Expert Panels that created the CCM credential in 1992. She is the author of* The Case Manager's Handbook, *now going into its sixth edition.*

Born in the Digital Age

There is a reason millennials do everything on their mobile devices. They do not know anything else. They were born into the digital age. Nielsen reported that 85% of millennials own smart phones. Communicating via Smartphone texts, email, and social media is the way they communicate. They also retrieve information differently than previous generations. Whereas their parents and grandparents relied on books and libraries for information, they retrieve information largely online. When it comes to their health and fitness, they rely on mobile apps and fitness trackers. RunKeeper, White Noise Lite, and Instant Heart Rate are just some of the mobile health apps that millennials use. Fitbit, Jawbone, and Garmin are just some of devices they use to track their activity and monitor their progress.

Given their propensity towards technology and the instant access to information it affords, it is understandable why millennials have also been designated the "instant gratification" generation. That too has influenced how they interact with the healthcare system and their expectations of it. They are not about to wait in a doctor's office for hours when they believe a retail clinic or urgent care center will address their problem faster. Further, wherever they receive care, and due in part to their being digital natives, they expect a certain level of attention. There is a name that has been given to the type of experience they expect. It is the "Apple experience" which gets its name from Apple stores and the retail experience they provide. It is characterized by a high level of convenience, personalization, transparency, and social engagement.

One might think this would contradict the millennials' inclination toward telehealth (that is, the use of telecommunications technologies to facilitate long distance health care including video chats with physicians, and physicians' diagnoses and prescribing of medications virtually, absent of seeing a patient). This, however, is not the case. According to a 2015 Harris Poll, 74% of millennials surveyed have a strong interest in telehealth. Furthermore, the poll found that 71% of millennials would like their healthcare providers to offer them mobile apps for appointment scheduling, health information, and preventive care advice. For those healthcare providers who meet these expectations, millennials will take to social media and share positive reviews with their friends and followers. For those that disappoint them, they will just as quickly post negative comments. This is particularly significant when you consider the finding of a recent Salesforce survey presented in its "State of the Connected Patients" report. It found that 76% of millennials rely on online physician reviews by other patients when selecting a doctor. Other findings of the Salesforce survey, which reflect millennials' expectation that

Further, wherever they [millennials] receive care, and due in part to their being digital natives, they expect a certain level of attention. There is a name that has been given to the type of experience they expect. It is the "Apple experience…."

technology be leveraged by healthcare providers include:

- 63% would like to be able to provide their health data from their WiFi/ wearable devices to their doctor/ healthcare provider for monitoring their health
- 74% value the ability to book medical appointments and pay medical bills online
- 73% would like their doctors to use mobile devices during appointments to share information

Fiscally Prudent Millennials

The high costs of health care are not lost on millennials. Unlike many of their elders, millennials seek out cost information before they schedule a medical procedure. An online consumer survey by PNC Healthcare found that 41% of millennials will request and receive estimates before undergoing medical treatments compared to only 18% of seniors and 21% of baby boomers. Millennials are also more likely to ask for discounts and to appeal an insurance decision than the other generations. In part, this is because millennials may have less money set aside for health care and need to be more cost-conscious. Many may still be carrying student debt and earning lower wages than their senior counterparts. So even if their yearly healthcare costs are lower, they represent a higher percentage of their overall expenses. Currently, the Kaiser Family Foundation estimates the average annual medical costs for treating a millennial is $1,834, while the average annual costs for individuals aged 35 to 44 is $2,739 and for individuals aged 45 to 64, it's $5,511. Besides the obvious reason for their lower healthcare costs (ie, their youth and thus fewer health problems associated with aging), millennials also have adopted different attitudes and behaviors relating to their health and well-being. Millennials are also helping to drive price transparency in health care. Remember, these digital natives have been able to access and compare online prices for everything from airfares and hotels to electronics and cars, and they expect nothing less from healthcare providers.

Health Behaviors of Millennials

For millennials, staying healthy is a mantra. Many are extremely conscious of their eating and exercising habits and focus on maintaining healthy behaviors. They generally take a more holistic view of health and wellness, believing if they eat well and exercise regularly they will stave off some of the health problems that have plagued the older generations. While many can name at least one fitness activity they do regularly, the medical scheduling company, ZocDoc, found that 93% do not schedule preventive physician visits and 51% visit a physician less often than once a year. In keeping with their behaviors relating to physician visits and relationships, a Salesforce survey found that almost 50% of millennial respondents have no personal relationship with their primary care physician.

Another common trait of millennials is their inclination to try to solve their medical problems independently. They rely on online health sites such as WebMD, Yahoo! Health, and the Mayo Clinic to check out their symptoms and attempt to treat their problems themselves first before seeing a doctor. Further, despite being frugal when it comes to spending on health care, their avoidance of physicians extends to their also not accessing preventive services even when they are free, believing that ultimately there will be costs associated with the "free" service. This is according to Young Invincibles, a nonprofit lobbying organization advocating for youth in healthcare reform.

Millennials' Impact on Case Management

The technology proclivity, fiscal prudence, and health behaviors of millennials are and will continue to affect how health care is provided to this generation. For case managers, the ramifications are becoming apparent in the skills they need, the tasks they perform, new ethical concerns, and practice settings, especially considering that technology is now playing a much more significant role in health care than ever before. Electronic health records (EHRs), for example, advanced by the Affordable Care Act's linking of federal incentives to the meaningful use of EHRs, are now widespread. For starters, case managers need to be skilled at using EHRs—inputting data and accessing the information they need to perform their role. Having instant access to their personal health records (ie, their medical history, clinical data, lab tests, medications, and treatments) is a high priority for millennials, who are already predisposed to self-managing their health care.

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Remember, these digital natives have been able to access and compare online prices for everything from airfares and hotels to electronics and cars, and they expect nothing less from healthcare providers.

a millennial patient, EHRs are critical tools in building the relationship, facilitating care coordination, and advancing targeted outcomes. Risks arise if these records are inaccurate or incomplete, leading to one or more medical errors, or are subject to a data breach. In the former instance, case managers may develop a plan based on erroneous data. In the latter situation, case managers must be certain that their computer systems and mobile devices are secure and in adherence to the Omnibus Rule, which requires that end user devices be designed to encrypt by default. Under legislation such as the Health Insurance Portability and Accountability Act (HIPAA) and the Federal Trade Commission's Red Flags Rule, there is also a responsibility to develop and enforce policies and procedures that protect consumers against identity theft. As for situations in which a computer system failure prevents a case manager from accessing a patient's EHR, the case manager could face serious ethical issues. Specifically, the inability to access a patient's records could potentially compromise case manager's ethical tenets of:

- Beneficence: To do good
- Non-malfeasance: To do no harm
- Fidelity: To follow-through and keep promises

as stated in the CMSA's "Statement Regarding Ethical Case Management Practice."

Case managers providing services via a telehealth arrangement with a millennial patient also need to continue to adhere to their professional ethics, as well as various regulatory guidelines and standards, which are evolving. The Food and Drug Administration has issued guidelines within its "Medical Devices Data Systems, Medical Image Storage Devices, and Medical Image Communications Devices," and "Mobile Medical Applications." More recently, however, many other organizations are calling for improved, evidence-based telehealth practice standards and guidelines. Among these organizations are the American Telemedicine Association (ATA), National Council of State Boards of Nursing (NCSBN), and the Joint Commission (formerly JCAHO). These guidelines and advancing standards require that case managers carefully monitor their telehealth practices provided via call centers and electronic, video, or digital communications. The goal of case managers should be adhering to their professional standards and codes of conduct and staying abreast of changing regulatory guidelines for telehealth practices designed to protect a patient's medical records and privacy.

Case managers could moderately be affected by millennials' cost-conscious healthcare consumption. They may find millennials asking questions regarding the costs associated with prescribed medications, tests, and procedures. Furthermore, millennials may frequently ask their case manager to offer an opinion about the "value" of these various treatment plan elements. As a result, case managers may need to raise their knowledge relating to the costs associated with various drugs, diagnostic tests, and medical procedures. Additionally, some millennials may rely on their case manager for advice and referrals to other professionals (eg, financial planners, insurance representatives) to help them address the cost factors associated with their treatment plans in a way that best accommodates their needs. For example, high-deductible health care plans such as health savings accounts (HSAs) especially appeal to millennials' fiscal nature. HSAs enable individuals to pay for their current healthcare expenses with tax-deductible contributions or through payroll deductions that are pretax, while earning interest tax-free and enabling tax-free withdrawals for qualified medical expenses.

Caring for Millennials in the Concierge Setting

Despite their frugality, millennial patients' desire for more convenient, tech-driven, and accessible personalized health care may incline them to enter into a concierge medicine arrangement. In concierge medicine, the patient is able to control their health and wellness goals with one-on-one guidance from a primary care physician. When serving a millennial patient in a concierge medicine relationship, the physician gets a full 360° picture of the individual's lifestyle, health and fitness habits, nutritional profile, and medical history. Often, a concierge medicine relationship starts with the physician ordering a full suite of medical screenings to establish a benchmark for the patient's health and ongoing monitoring. Along with the ability to access the physician through a 24/7 pager, email, or cell phone option,

there are weekend and extended hour appointments, as well as house calls, when needed.

The costs associated with a concierge medicine arrangement vary with annual fees ranging from an estimated $2,000 to $5,000 and monthly fees ranging anywhere from approximately $50 to over $200. The majority of the estimated 12,000 physicians involved in concierge medicine accept insurance, while others operate on a cash basis. A clause in the Affordable Care Act permits direct primary care to be regarded as ACA-compliant insurance with the caveat that it be bundled with wraparound catastrophic medical policies for emergency coverage. With this clause in place, some of the major health insurers, like Cigna, have created health plans encompassing concierge medicine.

The concierge model, how it provides services, and how they are paid for can become an issue for case managers serving in this practice setting. Generally, these issues involve Medicare reimbursements which, for most millennials, would not be an issue. Where Medicare coverage is the primary coverage for a millennial patient, there could be issues relating to what services are and are not covered (eg, certain screenings at certain times, specific medical treatments, consultations via electronic means, house calls). When guiding their millennial patients involved in a concierge medicine arrangement, case managers must be knowledgeable regarding the various stipulations of their patients' insurance, whether it is through a health maintenance organization (HMO), preferred provider organization (PPO) arrangement, hybrid plan such as a HSAs or health reimbursement accounts (HRAs), or government-paid coverage.

Millennial-Driven Health Care

Millennials are already the largest generation with growing clout across many sectors including health care. The healthcare system they are driving is very different from the one their parents and grandparents have known. If millennials have their way, and for all intents and purposes, they are getting their way, there will be a healthcare system that focuses on a holistic approach to health care incorporating preventive health measures. It will focus on healthy rather than sick and reward (with financial incentives) healthy behaviors instead of promoting excessive testing, procedures, and

continues on page 32

PharmaFacts for Case Managers

New Approvals

Descovy® (emtricitabine and tenofovir alafenamide) tablets, for oral use

Black Box Warning: Lactic Acidosis/Severe Hepatomegaly with Steatosis and Post-Treatment Acute Exacerbation of Hepatitis B

- Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs.
- Descovy is not approved for the treatment of chronic hepatitis B virus (HBV) infection. Severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HIV-1 and HBV and have discontinued products containing emtricitabine (FTC) and/or tenofovir disoproxil fumarate (TDF), and may occur with discontinuation of Descovy. Hepatic function should be monitored closely in these patients. If appropriate, initiation of anti-hepatitis B therapy may be warranted.

Indications and Usage

Descovy is a two-drug combination of emtricitabine (FTC) and tenofovir alafenamide (TAF), both HIV nucleoside analog reverse transcriptase inhibitors (NRTIs), and is indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients 12 years of age and older.

Limitations of Use:

Descovy is not indicated for use as pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk.

Dosage and Administration

- Testing: Before initiating Descovy, patients should be tested for hepatitis B virus infection, and estimated creatinine clearance, urine glucose,e and urine protein should be obtained.
- Recommended dosage: One tablet taken once daily with or without food in patients 12 years old and older with body weight at least 35 kg and a creatinine clearance ≥ 30 mL/minute.

Contraindications

None.

Drug Interactions

Consult the Full Prescribing Information prior to and during treatment for potential drug interactions.

Warnings and Precautions

- Redistribution/accumulation of body fat: Observed in patients receiving antiretroviral therapy.
- Immune reconstitution syndrome: May necessitate further evaluation and treatment.
- New onset or worsening renal impairment: Assess creatinine clearance, urine glucose, and urine protein in all patients before starting Descovy therapy and monitor throughout therapy. Monitor serum phosphorus in patients with chronic kidney disease.
- Bone loss and mineralization defects: Consider monitoring bone mineral density (BMD) in patients with a history of pathologic fracture or other risk factors of osteoporosis or bone loss.

Adverse Reactions

Most common adverse reaction (incidence ≥ 10%, all grades) is nausea.

Use in Specific Populations

Lactation: Women infected with HIV should be instructed not to breastfeed because of the potential for HIV transmission.
Pediatrics: Not recommended for patients younger than 12 years or weighing < 35 kg.

Clinical Studies

In trials of FTC+TAF with EVG+COBI in HIV-1 infected adults as initial therapy in those with no antiretroviral treatment history (N=866) and to replace a stable antiretroviral regimen in those who were virologically suppressed for at least 6 months with no known resistance substitutions (N=799), 92% and 96% of patients in the two populations, respectively, had HIV-1 RNA < 50 copies/mL at Week 48.

In a trial of FTC+TAF with EVG+COBI in 23 treatment-naïve HIV-1 infected pediatric patients aged 12 to younger than 18 years old and weighing > 35 kg, the virologic response rate (ie, HIV-1 RNA < 50 copies/mL) was 91% at 24 weeks.

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In a trial in 248 HIV-1 infected adult patients with estimated creatinine clearance greater than 30 mL/minute but < 70 mL/minute, 95% (235/248) of the combined population of treatment-naïve subjects (N=6) began on FTC+TAF with EVG+COBI and those previously virologically suppressed on other regimens (N=242) and switched to FTC+TAF with EVG+COBI had HIV-1 RNA < 50 copies/mL at Week 24.

How Supplied/Storage and Handling

Descovy 200 mg/25 mg tablets are blue, rectangular-shaped, and film-coated with "GSI" debossed on one side and "225" on the other side. Each bottle contains 30 tablets (NDC 61958-2002-1), a silica gel desiccant, polyester coil, and is closed with a child-resistant closure. Store below 30°C (86°F).

- Keep container tightly closed.
- Dispense only in original container.

Descovy is manufactured by Gilead Sciences, Inc.

Inflectra (infliximab-dyyb) for Injection, for Intravenous Use

Black Box Warning: Serious Infections and Malignancy Serious Infections

Patients treated with infliximab products are at increased risk for developing serious infection that may lead to hospitalization or death. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids.

Inflectra should be discontinued if a patient develops a serious infection or sepsis. Reported infections include:

- Active tuberculosis, including reactivation of latent tuberculosis. Patients with tuberculosis have frequently presented with disseminated or extrapulmonary disease. Patients should be tested for latent tuberculosis before Inflectra use and during therapy. Treatment for latent infection should be initiated prior to Inflectra use.
- Invasive fungal infections, including histoplasmosis, coccidioidomycosis, candidiasis, aspergillosis, blastomycosis, and pneumocystosis. Patients with histoplasmosis or other invasive fungal infections may present with disseminated, rather than localized, disease. Antigen and antibody testing for histoplasmosis may be negative in some patients with active infection. Empiric anti-fungal therapy should be considered in patients at risk for invasive fungal infections who develop severe systemic illness.
- Bacterial, viral and other infections due to opportunistic pathogens, including Legionella and Listeria.

The risks and benefits of treatment with Inflectra should be carefully considered prior to initiating therapy in patients with chronic or recurrent infection.

Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with Inflectra, including the possible development of tuberculosis in patients who tested negative for latent tuberculosis infection prior to initiating therapy.

Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, including infliximab products.

Postmarketing cases of hepatosplenic T-cell lymphoma (HSTCL), a rare type of T-cell lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, including infliximab products.

Indications and Usage

Inflectra is a tumor necrosis factor (TNF) blocker indicated for:

Crohn's Disease:

- Reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.
- Reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing disease.

Pediatric Crohn's Disease:

- Reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

Ulcerative Colitis:

- Reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy.

Rheumatoid Arthritis in combination with methotrexate:

- Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active disease.

Ankylosing Spondylitis:

- Reducing signs and symptoms in patients with active disease.

Psoriatic Arthritis:

- Reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function.

Plaque Psoriasis:

- Treatment of adult patients with chronic severe (ie, extensive and /or disabling) plaque psoriasis who are candidates for systemic therapy and when other systemic therapies are medically less appropriate.

Dosage and Administration

Inflectra is administered by intravenous infusion over a period of not less than 2 hours.

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some adult patients who initially respond to treatment may benefit from increasing the dose to 10 mg/kg if they later lose their response.

Pediatric Crohn's Disease

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

Ulcerative Colitis

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

Rheumatoid Arthritis

- In conjunction with methotrexate, 3 mg/kg at 0, 2 and 6 weeks, then every 8 weeks. Some patients may benefit from increasing the dose up to 10 mg/kg or treating as often as every 4 weeks.

Ankylosing Spondylitis

- 5 mg/kg at 0, 2 and 6 weeks, then every 6 weeks.

Psoriatic Arthritis and Plaque Psoriasis

- 5 mg/kg at 0, 2 and 6 weeks, then every 8 weeks.

Dosage Forms and Strengths

For injection: 100 mg of lyophilized infliximab-dyyb in a 20-mL vial for intravenous infusion.

Contraindication

Inflectra doses > 5 mg/kg in moderate to severe heart failure. Previous severe hypersensitivity reaction to infliximab products, or known hypersensitivity to inactive components of Inflectra or to any murine proteins.

Warnings and Precautions

- Serious infections—do not give Inflectra during an active infection. If an infection develops, monitor carefully and stop Inflectra if infection becomes serious.
- Invasive fungal infections—for patients who develop a systemic illness on Inflectra, consider empiric antifungal therapy for those who reside or travel to regions where mycoses are endemic
- Malignancies—the incidence of malignancies including lymphoma was greater in TNF blocker treated patients than in controls. Because of the risk of HSTCL carefully assess the risk/benefit especially if the patient has Crohn's disease or ulcerative colitis, is male, and is receiving azathioprine or 6mercaptopurine treatment.
- Hepatitis B virus (HBV) reactivation—test for HBV infection before starting Inflectra. Monitor HBV carriers during and several months after therapy. If reactivation occurs, stop Inflectra and begin anti-viral therapy.
- Hepatotoxicity—rare severe hepatic reactions, some fatal or necessitating liver transplantation. Stop Inflectra in cases of jaundice and/or marked liver enzyme elevations.
- Heart failure—new onset or worsening symptoms may occur.
- Cytopenias—advise patients to seek immediate medical attention if signs and symptoms develop, and consider stopping Inflectra.
- Hypersensitivity—serious infusion reactions including anaphylaxis or serum sickness-like reactions may occur.
- Demyelinating disease—exacerbation or new onset may occur.
- Lupus-like syndrome—stop Inflectra if syndrome develops.
- Live vaccines or therapeutic infectious agents – should not be given with Inflectra. Bring pediatric patients up to date with all vaccinations prior to initiating Inflectra. At least a six month waiting period following birth is recommended before the administration of live vaccines to infants exposed in utero to infliximab products

Adverse Reactions

Most common adverse reactions (> 10%) – infections (eg, upper respiratory, sinusitis, and pharyngitis), infusion-related reactions, headache, and abdominal pain.

Use in Specific Populations

Pediatric Use—Inflectra has not been studied in children with Crohn's disease or ulcerative colitis < 6 years of age.

Drug Interactions

Use with anakinra or abatacept—increased risk of serious infections

Clinical Studies

Clinical studies have been completed in patients with Crohn's disease, pediatric Crohn's disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, and plaque psoriasis. More information can be found at the FDA.

Inflectra is manufactured by Celltrion. 

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.

BMC Gastroenterol. 2016 Apr 4;16(1):45. doi: 10.1186/s12876-016-0438-z.

Implementation of baby boomer hepatitis C screening and linking to care in gastroenterology practices: a multi-center pilot study.

Younossi ZM, LaLuna LL, Santoro JJ, et al.

BACKGROUND: Estimates suggest that only 20 % of HCV-infected patients have been identified and <10 % treated. However, baby boomers (1945-1965) are identified as having a higher prevalence of HCV which has led the Centers for Disease Control and Prevention to make screening recommendations. The aim of this study was to implement the CDC's screening recommendations in the unique setting of gastroenterology practices in patients previously unscreened for HCV. METHODS: After obtaining patient informed consent, demographics, clinical and health-related quality of life (HRQOL) data were collected. A blood sample was screened for HCV antibody (HCV AB) using the OraQuick HCV Rapid Antibody Test. HCV AB-positive patients were tested for presence of HCV RNA and, if HCV RNA positive, patients underwent treatment discussions. RESULTS: We screened 2,000 individuals in 5 gastroenterology centers located close to large metropolitan areas on the East Coast (3 Northeast, 1 Mid-Atlantic and 1 Southeast). Of the screened population, 10 individuals (0.5 %) were HCV AB-positive. HCV RNA testing was performed in 90 % (9/10) of HCV AB-positive individuals. Of those, 44.4 % (4/9) were HCV RNA-positive, and all 4 (100 %) were linked to caregiver. Compared to HCV AB negative subjects, HCV AB-positive individuals tended to be black (20.0 vs. 5.2 %, $p = 0.09$) and reported significantly higher rates of depression: 60.0 vs. 21.5 %, $p = 0.009$. These individuals also reported a significantly lower HRQOL citing having more fatigue, poorer concentration, and a decreased level of energy ($p < 0.05$). DISCUSSION: Although the prevalence of HCV AB-positive was low in previously unscreened subjects screened in the gastroenterology centers, the linkage to care was very high. The sample of patients used in this study may be biased, so further studies are needed to assess the effectiveness of the CDC screening recommendations. CONCLUSION: Implementation of the Baby Boomer Screening for HCV requires identifying screening environement with high prevalence of HCV+ individuals as well as an efficient process of linking them to care.

AIDS. 2016 Apr 6. [Epub ahead of print]

Facilitators and barriers in HIV linkage to care interventions: a qualitative evidence review.

Tso LS1, Best J, Beanland R, et al.

OBJECTIVE: To synthesize qualitative evidence on linkage to care interventions for people living with HIV. DESIGN: Systematic literature review. METHODS: We searched nineteen databases for studies reporting qualitative evidence on linkage interventions. Data extraction and thematic analysis were used to synthesize findings. Quality was assessed using the CASP tool and certainty of evidence was evaluated using the CERQual approach. RESULTS: Twenty-five studies from eleven countries focused on adults (24 studies), adolescents (8 studies), and pregnant women (4 studies). Facilitators included community-level factors (i.e. task-shifting, mobile outreach, integrated HIV and primary services, supportive cessation programs for substance users, active referrals, and dedicated case management teams) and individual-level factors (encouragement of peers/family and positive interactions with healthcare providers in transitioning into care). One key barrier for people living with HIV was perceived inability of providers to ensure confidentiality as part of linkage to care interventions. Providers reported difficulties navigating procedures across disparate facilities and having limited resources for linkage to care interventions. CONCLUSIONS: Our findings extend the literature by highlighting the importance of task-shifting, mobile outreach, and integrated HIV and primary services. Both community and individual level factors may increase the feasibility and acceptability of HIV linkage to care interventions. These findings may inform policies to increase the reach of HIV services available in communities.

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Eur J Cardiothorac Surg. 2016 Mar 31. pii: ezw108. [Epub ahead of print]

Era effect on survival following paediatric heart transplantation.

Alsoufi B, Deshpande S, McCracken C, et al.

OBJECTIVES: Paediatric heart transplantation is performed to salvage children with end-stage heart failure from various underlying pathologies. Despite several developments in all management aspects of transplantation candidates, the effect of those advances on outcomes has not been consistent. We report our institutional experience with focus on examining era effect on early and late survival. METHODS: Between 1988 and 2015, 320 children underwent heart transplantation. Competing risk analysis modelled events after transplantation (retransplantation, death without retransplantation). Multivariable parametric risk hazard analysis examined the risk factors affecting survival. RESULTS: Patients were divided to three groups based on underlying pathology: congenital group (n = 132, 41%), acquired group (n = 153, 48%) and retransplant group (n = 35, 11%). Competing risk analysis showed that at 10 years following transplantation, 11% of patients had undergone retransplantation, 39% had died without retransplantation and 44% were alive without retransplantation. Ten-year survival was 61, 51 and 45% for acquired, congenital and retransplant groups, respectively. Overall, survival following heart transplantation for the late era (2005-15) was 63% compared with 49% for the early era (1988-2004) at 10 years (P = 0.022). Compared with early era, 1-year survival in the late era was 84 vs 79% {odds ratio (OR): 0.72 [95% confidence interval (CI) 0.3-1.8], P = 0.470} for congenital, 98 vs 86% [OR: 0.14 (95% CI 0.03-0.68), P = 0.006] for acquired and 73 vs 88% [OR: 2.6 (95% CI 0.4-1.9), P = 0.282] for retransplant. The effect of late era on survival was not significant for congenital [hazard ratio (HR) 0.6 (95% CI 0.2-1.4), P = 0.206] or retransplant patients [HR: 1.7 (95% CI 0.5-5.5), P = 0.400], but showed improvement trend for acquired patients [HR: 0.53 (95% CI 0.3-1.0), P = 0.052]. CONCLUSIONS: The era effect on early survival following heart transplantation is related to underlying pathology; there is a significant improvement in early survival in children with acquired pathology, whereas there is no significant change in early survival in children with congenital pathology or failed prior transplantation. This suggests a potential area for improvement that might include pretransplant stabilization and management of immunosuppression. On the other hand, era effect on late survival is not significant. This demonstrates that advances in the care of paediatric heart transplantation patients have not affected ongoing problems that diminish late survival.

Lancet Infect Dis. 2016 Mar 30. pii: S1473-3099(16)00124-9. doi: 10.1016/S1473-3099(16)00124-9. [Epub ahead of print]

The spread of hepatitis C virus genotype 1a in North America: a retrospective phylogenetic study.

Joy JB, McCloskey RM, Nguyen T, et al.

BACKGROUND: The timing of the initial spread of hepatitis C virus genotype 1a in North America is controversial. In particular, how and when hepatitis C virus reached extraordinary prevalence in specific demographic groups remains unclear. We quantified, using all available hepatitis C virus sequence data and phylodynamic methods, the timing of the spread of hepatitis C virus genotype 1a in North America. METHODS: We screened 45 316 publicly available sequences of hepatitis C virus genotype 1a for location and genotype, and then did phylogenetic analyses of available North American sequences from five hepatitis C virus genes (E1, E2, NS2, NS4B, NS5B), with an emphasis on including as many sequences with early collection dates as possible. We inferred the historical population dynamics of this epidemic for all five gene regions using Bayesian skyline plots. FINDINGS: Most of the spread of genotype 1a in North America occurred before 1965, and the hepatitis C virus epidemic has undergone relatively little expansion since then. The effective population size of the North American epidemic stabilised around 1960. These results were robust across all five gene regions analysed, although analyses of each gene separately show substantial variation in estimates of the timing of the early exponential growth, ranging roughly from 1940 for NS2, to 1965 for NS4B. INTERPRETATION:

The expansion of genotype 1a before 1965 suggests that nosocomial or iatrogenic factors rather than past sporadic behavioural-risk (ie, experimentation with injection drug use, unsafe tattooing, high risk sex, travel to high endemic areas) were key contributors to the hepatitis C virus epidemic in North America. Our results might reduce stigmatisation around screening and diagnosis, potentially increasing rates of screening and treatment for hepatitis C virus.

PLoS One. 2015 Apr 23;10(4):e0119265. doi: 10.1371/journal.pone.0119265. eCollection 2015.

Multimarker proteomic profiling for the prediction of cardiovascular mortality in patients with chronic heart failure.

Lemesle G, Maury F, Beseme O, et al.
Risk stratification of patients with systolic chronic heart failure (HF) is critical to better identify those who may benefit from invasive therapeutic strategies such as cardiac transplantation. Proteomics has been used to provide prognostic information in various diseases. Our aim was to investigate the potential value of plasma proteomic profiling for risk stratification in HF. A proteomic profiling using surface enhanced laser desorption ionization - time of flight - mass spectrometry was performed in a case/control discovery population of 198 patients with systolic HF (left ventricular ejection fraction <45%): 99 patients who died from cardiovascular cause within 3 years and 99 patients alive at 3 years. Proteomic scores predicting cardiovascular death were developed using 3 regression methods: support vector machine, sparse partial least square discriminant analysis, and lasso logistic regression. Forty two ion m/z peaks were differentially intense between cases and controls in the discovery population and were used to develop proteomic scores. In the validation population, score levels were higher in patients who subsequently died within 3 years. Similar areas under the curves (0.66 - 0.68) were observed for the 3 methods. After adjustment on confounders, proteomic scores remained significantly associated with cardiovascular mortality. Use of the proteomic scores allowed a significant improvement in discrimination of HF patients as determined by integrated discrimination improvement and net reclassification improvement indexes. In conclusion, proteomic analysis of plasma proteins may help to improve risk prediction in HF patients.

Chest. 2016 Apr 4. pii: S0012-3692(16)47556-2. doi: 10.1016/j.chest.2016.03.037. [Epub ahead of print]

Improving quality of acute asthma care in U.S. hospitals: changes between 1999-2000 and 2012-2013.

Hasegawa K, Tsugawa Y, Clark S, et al.
BACKGROUND: Little is known about the longitudinal change in quality of acute asthma care for hospitalized children and adults in the U.S. We investigated whether the concordance of inpatient asthma care with the national guidelines improved over time, identified hospital characteristics predictive of guideline concordance, and determined whether guideline-concordant care is associated with a shorter hospital length-of-stay (LOS). METHODS: Analysis of data from two multicenter chart review studies of hospitalized patients aged 2-54 years with acute asthma during two time periods: 1999-2000 and 2012-2013. Outcomes were guideline concordance at the patient- and hospital-levels, and association of patient composite concordance with hospital LOS. RESULTS: Analytic cohort for the comparison of guideline concordance comprised 1,634 patients: 834 patients from 1999-2000 versus 800 patients from 2012-2013. Over these 15 years, inpatient asthma care became more concordant at the hospital-level, with the mean composite score increasing from 74 to 82 (P<.001). However, during 2012-2013, wide variability in guideline concordance of acute asthma care remained across hospitals, with the greatest variation in provision of individualized written action plan at discharge (SD, 36). Guideline concordance was significantly lower in Midwestern and Southern hospitals compared to Northeastern hospitals. After adjusting for severity, patients who received care perfectly concordant with the guidelines had significantly shorter hospital LOS (-14%; 95%CI, -23% to -4%; P=.009). CONCLUSIONS: Between 1999 and 2013, the guideline concordance of acute asthma care for hospitalized patients improved. However, inter-hospital variability remains substantial. Greater concordance with evidence-based guidelines was associated with a shorter hospital LOS.

J Asthma. 2016 Apr 6:0. [Epub ahead of print]

Adapting and implementing an evidence-based asthma counseling intervention for resource-poor populations.

Thornton E, Kennedy S, Hayes-Watson C, et al.
OBJECTIVE: To report implementation strategies and outcomes of an evidence-based asthma counseling intervention. The Head-off Environmental Asthma in Louisiana (HEAL) intervention integrated asthma counseling (AC) capacity and addressed challenges facing children with asthma in post-disaster New Orleans. METHODS: The HEAL intervention enrolled 182 children (4-12 years) with moder-

ate-to-severe persistent asthma. Recruitment occurred from schools in the Greater New Orleans area for one year. Participants received home environmental assessments and tailored asthma counseling sessions during the study period based on the National Cooperative Inner City Asthma Study and the Inner City Asthma Study. Primary (i.e. asthma symptoms) and secondary outcomes (i.e. healthcare utilization) were captured. During the study, changes were made to meet the demands of a post-hurricane and resource-poor environment which included changes to staffing, training, AC tools, and AC sessions. RESULTS:

After study changes were made, the AC visit rate increased by 92.3%. Significant improvements were observed across several adherence measures (e.g., running out of medications (p = 0.009), financial/insurance problems for appointments (p = 0.006), worried about medication side-effects (p = 0.01), felt medications did not work (p<0.001)). Additionally, an increasing number of AC visits was modestly associated with a greater reduction in symptoms (test-for-trend p = 0.059). CONCLUSION: By adapting to the needs of the study population and setting, investigators successfully implemented a counseling intervention that improved participant behaviors and clinical outcomes. The strategies for implementing the AC intervention may serve as a guide for managing asthma and other chronic conditions in resource-poor settings.

BMC Cancer. 2016 Apr 1;16(1):260. doi: 10.1186/s12885-016-2290-5.

Systematic review: brain metastases from colorectal cancer-Incidence and patient characteristics.

Christensen TD, Spindler KL, Palshof JA, Nielsen DL.
BACKGROUND: Brain metastases (BM) from colorectal cancer (CRC) are a rare event. However, the implications for affected patients are severe, and the incidence has been reported to be increasing. For clinicians, knowledge about the characteristics associated with BM is important and could lead to earlier diagnosis and improved survival. METHOD: In this paper, we describe the incidence as well as characteristics associated with BM based on a systematic review of the current literature, following the PRISMA guidelines. RESULTS: We show that the incidence of BM in CRC patients ranges from 0.6 to 3.2 %. BM are a late stage phenomenon, and young age, rectal primary and lung metastases are associated with increased risk of developing BM. Molecular markers such as KRAS, BRAF, NRAS mutation as well as an increase in CEA and CA19.9 levels are suggested predictors of brain involvement. However, only KRAS mutations are reasonably well investigated and associated with an increased risk of BM. CONCLUSION: The incidence of BM from CRC is 0.6 to 3.2 % and did not seem to increase over time. Development of BM is associated with young age, lung metastases, rectal primary and KRAS mutation. Increased awareness of brain involvement in patients with these characteristics is necessary.

J Am Coll Surg. 2016 Feb 13. pii: S1072-7515(16)00146-0. doi: 10.1016/j.jamcollsurg.2016.01.061. [Epub ahead of print]

Inpatient rehabilitation after liver transplantation decreases risk and severity of 30-day readmissions.

Kothari AN, Yau RM, Blackwell RH, et al.
BACKGROUND: Discharge location is associated with short-term readmission rates after hospitalization for several medical and surgical diagnoses. We hypothesized that discharge location: home, home health, skilled nursing facility (SNF), long-term acute care (LTAC), or inpatient rehabilitation, independently predicted the risk of 30-day readmission and severity of first readmission after orthotopic liver transplantation. STUDY DESIGN: We performed a retrospective cohort review using Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases for Florida and California. Patients who underwent orthotopic liver transplantation from 2009 to 2011 were included and followed for 1 year. Mixed-effects logistic regression was used to model the effect of discharge location on 30-day readmission controlling for demographic, socioeconomic, and clinical factors. Total cost of first readmission was used as a surrogate measure for readmission severity and resource use. RESULTS: A total of 3,072 patients met our inclusion criteria. The overall 30-day readmission rate was 29.6%. Discharge to inpatient rehabilitation (adjusted odds ratio [aOR] 0.43, p = 0.013) or LTAC/SNF (aOR 0.63, p = 0.014) were associated with decreased odds of 30-day readmission when compared with home. The severity of 30-day readmissions for patients discharged to inpatient rehabilitation were the same as those discharged home or home with home health. Severity was increased for those discharged to LTAC/SNF. The time to first readmission was longest for patients discharged to inpatient rehabilitation (17 days vs 8 days, p < 0.001). CONCLUSIONS: When compared with other locations of discharge, inpatient rehabilitation reduces the risk of 30-day readmission and increases the time to first readmission. These benefits come without increasing the severity of readmission. Increased use of inpatient rehabilitation after orthotopic liver transplantation is a strategy to improve 30-day readmission rates.

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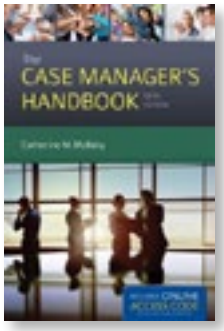

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PATIENTS LEAVE HOSPITAL WITH SUPERBUGS

Encouraging doctors and nurses to wash their hands frequently has always been considered an effective way to curb the spread of infection in hospitals and other health facilities.

But a research letter published Monday in *JAMA Internal Medicine* points to another key group of people who aren't always keeping their hands so clean and probably should: patients.

Researchers focused on inner-city Detroit and looked at patients who went from hospitals to post-acute care facilities—places like rehabilitation centers, skilled-nursing facilities, hospice and long-term care hospitals. They found that almost 1 in 4 adults who left the hospital had on their hands a superbug: a virus, bacteria or another kind of microbe that resists multiple kinds of medicine.

While in post-acute care, about 10 percent of patients picked up another superbug. Of those who had superbugs, 67 percent still had them upon being discharged, even if they hadn't gotten sick.

These findings add to a growing body of research about hand hygiene and the patient's role in infection transmission, and speak to a problem with health care facilitie —they can increase the odds of getting sick. ■

Health Care Dominates Best Jobs List

Nursing and other healthcare professions made their mark upon the *U.S. News and World Report*'s 2016 annual list of the best jobs in the United States.

THE LIST OF 100 BEST JOBS INCLUDED FIVE NURSING JOBS, INCLUDING THREE ADVANCED PRACTICE SPECIALTIES:

4. Nurse anesthetist
6. Nurse practitioner
22. Registered nurse
69. Licensed practical or vocational nurse
80. Nurse midwife

IN FACT, THE TOP FIVE JOBS OVERALL INCLUDED FOUR IN THE HEALTHCARE ARENA:

1. Orthodontist
2. Dentist
3. Computer Systems Analyst
4. Nurse anesthetist
5. Physician Assistant

THE BEST JOBS IN THE HEALTHCARE SUPPORT CATEGORY:

1. Occupational Therapy Assistant
2. Dental Hygienist
3. Orthodontist & Prosthetist
4. Physical Therapist Assistant
5. Diagnostic Medical Sonographer

See more at AMN Healthcare. ■

SUPERBUG-CONTAMINATED SCOPES

The number of patients sickened by carrying carbapenem-resistant Enterobacteriaceae (CRE) between 2010 and 2015 is much higher than the Food and Drug Administration previously reported, according to the results of a Congressional investigation obtained by *Kaiser Health News*.

Congressional investigators led by Rep. Ted Lieu (D-Calif.) found a link between tainted scopes and the cases of some 350 patients at 41 providers worldwide. The House Committee on Oversight and Government Reform said that it has evidence that contaminated duodenoscopes were responsible for:

- Up to 404 patient infections
- Forty-four additional patient exposures to contaminated devices
- Incidents at 41 facilities in the U.S. and abroad
- Thirty-four incidents in which patients were infected or exposed to contaminated devices
- More than 300 Medical Device Reports on patient infections, exposure and device contamination ■

New Hep C Tests Could Be Pivotal in Lowering Cost of Expensive Treatment

The test allows doctors to find the patient's specific type of hepatitis C, which can allow them to pick the most effective and, perhaps, less costly treatment. Meanwhile, New York's Attorney General Eric Schneiderman is suing an insurance provider, saying it denied coverage for hep C patients until they showed advance signs of the disease. ■

CMS Launches Largest-Ever Multipayer Initiative to Improve Primary Care

The Centers for Medicare & Medicaid Services (CMS) today announced its largest-ever initiative to transform and improve how primary care is delivered and paid for in America. The effort, the Comprehensive Primary Care Plus (CPC+) model, will be implemented in up to 20 regions and can accommodate up to 5,000 practices, which would encompass more than 20,000 doctors and clinicians and the 25 million people they serve. The initiative is designed to provide doctors the freedom to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care.

Building on the Comprehensive Primary Care initiative launched in late 2012, the five-year CPC+ model will benefit patients by helping primary care practices:

- Support patients with serious or chronic diseases to achieve their health goals
- Give patients 24-hour access to care and health information
- Deliver preventive care
- Engage patients and their families in their own care
- Work together with hospitals and other clinicians, including specialists, to provide better coordinated care

Read more at CMS. ■

FDA Will Review Opdivo for Hodgkin Lymphoma

The US Food and Drug Administration has accepted Bristol-Myers Squibb Co.'s supplemental biologics license application to expand the use of its cancer drug Opdivo to patients who are facing difficult-to-treat variations of Hodgkin lymphoma. ■

Stress on Nurses Interferes With Patient Care

Nursing has long been considered one of the most stressful professions, according to a review of research by the National Institute for Occupational Safety and Health at the Centers for Disease Control and Prevention in 2012. Nurses and researchers say it comes down to organizational problems in hospitals worldwide. That includes cuts in staffing; some California nurses struck last month for a week over low staffing and wages.
But some researchers say that just hiring more people won't fix things. Other proposed solutions include restructuring hospitals so that administrators pay more attention to what nurses have to say about patient care and work flow, and training programs to help nurses relieve their stress and deal with ethical dilemmas. Read more at: NPR.org. ■

Nearly Half of Patient-Doctor Interactions Missing From Electronic Records: Study

A new report from the *Journal of the American Medical Informatics Association* finds nearly half of patient face-to-face contact with health care providers—checkups, emergency room stays, even hospital admissions—were missing from their electronic records.

This paper appears to be the first to quantify the problem.

Harvard's Stephen Soumerai—one of the authors—says inaccurate electronic records like this are a safety threat.

"There are many studies now that show people are getting hurt because of the inability of systems to talk to each other," he said. ■

Rise In Oncologists Working For Hospitals Spurs Higher Chemo Costs: Study

A study by researchers at the University of Chicago analyzed private health insurance claims data from the Health Care Cost Institute, a nonprofit research organization, and national data about consolidation among doctors and hospitals between 2008 and 2013.

It found significant consolidation between outpatient oncology practices and health care systems in the decade leading up to 2013. The researchers linked that to a rise in spending on drug-based cancer care. Each 1% increase in the proportion of medical providers who were affiliated with a hospital or health system was associated with a 34% increase in annual average spending per person on outpatient cancer drug treatment, they reported.

This study suggests that for patients, it may be more cost-effective to get chemotherapy treatments at a community-based practice rather than a hospital or hospital-affiliated clinic. ■

Take Care—Geriatric Care Managers/Aging Life Care Managers

Recently, Amy Goyer, Caregiving & Multigenerational Family Issues Expert appeared on the Today Show to talk about her book, Juggling Life, Work and Caregiving. In her interview she gave several tips for individuals with aging loved ones and also provided additional detail through her blog posting.

In her interview and in her new book, Amy highlights the benefits of working with a geriatric care manager (like those we have at Peace Aging Care) and using the Aging Life Care Association organization as a resource to locate an experienced care manager. ■

Trends in Case Management Acuity Determination *continued from page 14*

has been validated in the literature would require extensive time, training and capital investment in order to integrate it into a new system. Any new acuity rating scale needs to be nimble enough to be easily integrated within the current operating framework which may include a risk assessment database as well as claims and nursing tracking program.

In summary, based on this review, there are no set guidelines for all CM settings in relation to acuity and levels of intervention. Thus each CM site needs to develop clear goals and objectives in order to determine best practices. Two predictive modeling concepts, the Care Gap Index and Relative Risk are promising tools to automate referrals to case management and potentially to identify acuity. Case management objectives in the insurance industry cannot be all inclusive of all the holistic goals based in primary care CM programs. The focus of case management by the insurer needs to be related to prevention of hospitalization by reducing care gaps and promoting compliance with best health care practices. **CE I**

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The Millennial Patient: Transforming Health Care *continued from page 19*

medications. It will be accessible, giving patients full ownership of their health records, and access to information about their healthcare providers' clinical outcomes, fees and prices. Information will be available electronically through secure mobile apps, website patient portals and electronic exchanges. Communications with healthcare professionals will be convenient, streamlined, paperless as much as possible, and ones in which patients have the opportunity to engage with their healthcare providers, ask questions, and fully understand their medical condition and prescribed treatment plan so that they can remain in control of their health. Case managers, who strive to guide patients in taking a more proactive role in their health management, will find the independent attitude of millennials refreshing and their transformative effect on our nation's healthcare system a force consistent with their primary goal, which is to improve patient care and deliver a better overall patient experience. **CE II**

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How many Ethics CEUs will CCMC require?

- *Certifications expiring in 2016: two (2) Ethics CEUs will be required for renewal.*
- *Certifications expiring in 2017: four (4) Ethics CEUs will be required for renewal.*
- *Certifications expiring 2018 and after: eight (8) Ethics CEUs will be required for renewal.*

More Proposed Changes in Discharge Planning for Critical Access Hospitals *continued from page 6*

- Smoking status
- Vital signs
- Unique device identifier(s) for patients' implantable devices, if any
- All special instructions or precautions for ongoing care, as appropriate
- Patients' goals and treatment preferences
- Any other necessary information, including copies of patients' discharge instructions, discharge summaries and any other documentation as applicable to ensure safe and effective transitions of care that support post-discharge goals for patients

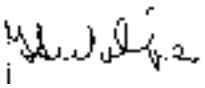
It seems unlikely that CMS will make substantial changes in these regulations when they are finalized. Discharge planners/case managers, now is the time to start getting ready! CM

Millennials and Health Care *continued from page 2*

concern of functional settings limiting who sees their online shares. This comfort with social media means they are good at self-promotion and fostering connections through online media.

In surveys, Millennials have been shown to have the least faith in the institutions of America. Conversely, they also show the highest support of political independents and protestor-formed governments. Although Millennials have less faith in religious institutions, at the same time the numbers have also risen for those who have absolute faith in the existence of a god. Many churches' messages clash with the Millennial ideal of tolerance for religious, racial, gender, and sexual orientation differences. Millennials are also concerned about social justice and will not support institutions that they see as in conflict with social and economic equality. As such, Millennials are exerting their influence on the world around them, as all prior generations have done.

The characteristics and beliefs of the Millennials make it challenging for the case manager. New approaches and strategies are needed to achieve health care outcomes obtainable and satisfactory to the Millennial. Millennials bring a new set of health behaviors to the health care environment. Mullahy in "The Millennial Patient: Transforming Health Care" in this issues brings insight for working with Millennials.



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ACCM: Improving Case Management Practice through Education

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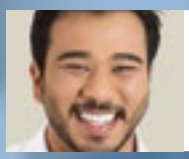

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