CareManagement

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

Vol. 26, No. 6 December 2020/January 2021

INSIDE THIS ISSUE

CONTINUING EDUCATION ARTICLES:

CE Exam CE

Members: Take exam online or print and mail.

Nonmembers:

Join ACCM to earn CE credits.

SPECIAL SECTIONS:

DEPARTMENTS:

Gary S. Wolfe

Change in Continuing Education Credits

The mission of *CareManagement* is to improve case management practice through education. *CareManagement*, the official publication of the Academy of Certified Case Managers and the Commission for Case Manager Certification and a publication of the Case Management Society of America, is published six times per year with articles that help case managers improve their practice and ultimately patient outcomes. Our articles have significantly contributed to the case management body of knowledge as the field of case management has grown into a profession. In the 26 years we have published *CareManagement*, we have offered over 800 hours of continuing education with exams that have been taken by over 35,000 case managers. In addition to publishing regular issues of *CareManagement*, we have published many supplements with continuing education. These supplements contain specific disease-centered knowledge for the case manager. All of our continuing education has been approved by the Commission for Case Manager Certification (CCMC), the Certified Disability Management Specialist, and the California Board of Registered Nursing. We are proud to make this contribution to the case management body of knowledge.

CCMC has changed their guidelines for continuing education offered solely through written means such as those offered in *CareManagement*. In the past, the number of hours each accredited course offered was solely based on word count. According to the CCMC, contact hours are now determined in a logical and defensible manner. Contact hours are awarded for those portions of the educational activity devoted to the learning experience and time spent evaluating the activity. This new method will use the Mergener Formula, which may include but is not limited to the complexity of content. The Mergener Formula allows for an a priori method of assigning continuing education units based upon the estimated time it takes to complete the self-study—reading the course and completing the learner assessment. The formula is based on the number of words in the text, the number of learner assessment questions, and a subjective assessment of the difficulty level of the content using a 5-point Likert scale.

What this means to you and to *CareManagement* is that most of our self-study articles will now carry one continuing education credit. In the past we have published two continuing education articles carrying four units of credit, but we will now we be publishing three self-study articles carrying a total of three units of credit in each issue.

CareManagement will now provide over 90 hours of continuing education credits in each 5-year renewal period. The number of continuing education credits we offer will exceed the requirement for our certification renewal. We will continue to publish at least two approved articles on ethics each year providing 10 hours of continuing education credit in each 5-year period. We will also continue to publish supplements.

CareManagement provides value-based continuing education for the case manager. Self-study allows you to take continuing education in your own environment and at your own time. Self-study reduces the anxiety associated with trying to get the required number of continuing education credits for renewal at the last minute. Using your CCMC

continues on page 33

CareManagement

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

Vol. 26, No. 6, December 2020/January 2021. *CareManagement* (ISSN #1531-037X) is published electronically six times a year, February, April, June, August, October, and December, and its contents are copyrighted by Academy of Certified Case Managers, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990; Tel: 203-454-1333; Fax: 203-547-7273.

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

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

Genex Case Manager
Sara Fleming, RN, CCM

Creating a Brighter Future for Those We Serve

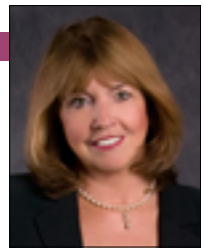
Join the most experienced managed care provider in the industry. Genex delivers clinical services and solutions that improve productivity, contain costs, and help injured workers get better faster. As a managed care specialist, you'll work with workers' compensation payers and risk managers to achieve superior results. Our case managers address the unique needs of each company and each injured employee, building trust one relationship at a time.

Career opportunities with Genex:

- Utilization Review Nurses (RNs)
- Field & Telephonic Case Managers (RNs)
- Vocational Counselors/Case Managers
- Sales Professionals

To view a listing of opportunities in your area visit our website at **genexservices.com/careers**

genex®



Catherine M. Mullahy

Reflections and Celebrations

In this last issue of 2020 and first issue of 2021, it's befitting to look back a bit and then to look forward. What a strange, unsettling year 2020 has been, dominated largely by the pandemic and all of its ramifications. The loss of lives, jobs, and businesses as well as the impact on our daily freedom was unprecedented. One good thing that came from the pandemic was the focus on our frontline heroes; they deserve all the recognition they have received. On the "good news" front, at least two vaccines for COVID-19 should be ready soon and large-scale clinical trials have indicated they are effective by more than 94%–95%. In comparison, the flu vaccine is only 40%–50% effective. While it will take time for this vaccine to be available for all who need or want it, this is incredibly good news.

The other news concerns the presidential election. At this writing, the results in all 50 states have yet to be certified by Congress, and it is possible that the election process could end up in the Supreme Court. So, we may well enter the new year with many questions and concerns about our health and our nation's health. How many people will take the vaccine for COVID-19 when the flu vaccine, which has been in existence for many more years and is considered safe, is taken by ≤50% of us? Will the election resolve our nation's problems or will our differences continue to divide us? Hopefully, the New Year will bring well-being to each of us and to our country as well as better days ahead.

Case management will continue to be challenged by the pandemic and so much more. Yet it's often those very challenges that inspire us to reach beyond what seems to be impossible to find win-win solutions. While others along the care continuum might elect to provide their care in a more predictable environment, those who choose case management are often the ones who are "running into a burning building" rather than looking for an escape.

While others along the care continuum might elect to provide their care in a more predictable environment, those who choose case management are often the ones who are "running into a burning building" rather than looking for an escape.

CareManagement, as always, tries to bring you the kind of information that we hope will inspire you to reach your professional and personal goals. Moreover, it is the mission of this publication to also provide the continuing education that will both advance your goals and promote improved patient outcomes.

What has this year taught us and what will the next year bring? Surely, 2020 was like no other year and we will all be glad to bid it farewell. Healthcare professionals, including case managers, have been acknowledged as true frontline heroes to whom a debt of gratitude can never be repaid.

In November, other heroes were recognized—the men and women actively serving in the military and our proud veterans. Case managers who are providing their intervention in those practice settings have also made notable contributions. Many of their innovative programs have served as prototypes for their colleagues in the civilian sector. Additionally, because of legislative changes, many veterans are now able to use their benefits in the private sector. We hope that case managers from the military and Department of Veterans Affairs will be able to share their valuable knowledge and experience in *CareManagement*. This will enable us to better understand the challenges facing those who have served our country. In this issue, the current National President of CMSA, Melanie A. Prince, RN, MSN, RN-BC, CCM, a recently retired Air Force colonel, wrote a column that salutes military and Veterans Affairs case managers. We are proud to be the first case management publication to launch a column that acknowledge the contributions not only of those who have served but also of the front-line case managers who are providing their intervention.

There are always mixed feelings as we bid farewell to the current year and look with some uncertainty to the next one, but this year is different. Most of us are more than happy to look into 2021 with determined optimism that it will be a better year than 2020.

Happy Holidays!

Catherine M. Mullahy

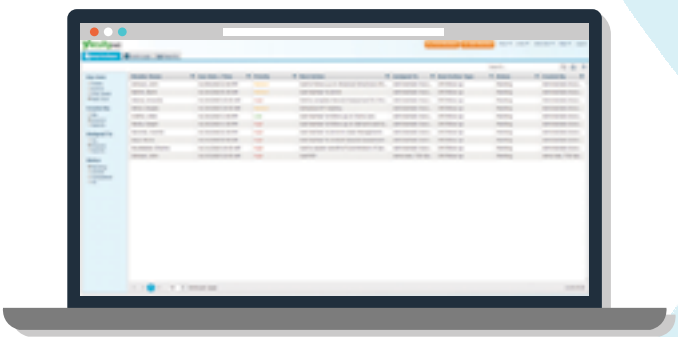
Catherine M. Mullahy, RN, BS, CCRN, CCM, Executive Editor
cmullahy@academyccm.org

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

Yacuitynxt

Population Health Designed by Clinicians

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



ACUITYnxt Supports:

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

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

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

Secure Healthcare Cloud

TCS HEALTHCARE™ TECHNOLOGIES

To learn more:
www.tcshealthcare.com
530.886.1700

Making the Most of Virtual Training

Sandra Zawalski, MSN, RN, CRRN, CCM, ABDA, MSCC

In the past, case managers typically received in-person training to learn new procedures or transition to a technology platform. With the pandemic, however, training went virtual—and everything changed.

As a trainer, I went from traveling 3 weeks out of every month for onsite training to teaching people virtually—sometimes several hundred people at a time. Virtual learning seeks to replicate in-person training sessions with livestreaming instruction. This is not online learning, with videos, learning material, and quizzes that appear on the screen at each learner's pace. Rather, virtual learning brings together groups of people with an instructor in a live session via a teleconference platform. According to training industry experts, virtual instructor–led training is an effective, efficient way to teach people, particularly when imparting technical skills.

As a trainer, now certified in virtual learning, I had to adapt my teaching style to this new norm. One of the challenges I encountered was not being able to observe body language, as I do in person, for indications of confusion or questioning—as well as those "aha moments" when something new suddenly makes sense. In virtual training, I've had to become more proactive; for example, I frequently check in with learners, asking them for feedback and reactions. Sometimes it's as simple as asking them to send an emoji.

Another challenge has been ensuring that people stayed engaged during virtual training. I've found that interjecting small activities every 7 to 10 minutes—for example, polling the class with a question—helps reengage everyone.

According to training industry experts, virtual instructor–led training is an effective, efficient way to teach people, particularly when imparting technical skills.

While widespread adoption of virtual training has been a transition for all involved, it reminds us of the importance of being adaptable. As case managers, we need to be flexible and responsive to the changing demands of our workplace and practice settings. Being stretched by virtual learning and the technology component can help case managers feel more adaptable overall while increasing their technology savviness.

Engaging with Virtual Training

Based on my experiences, here are several tips that can help case managers and others to get the most out of virtual training:

- Know the platform you will be using (eg, GoToMeeting, Zoom, or WebEx). Don't be afraid to ask for help. Practice signing in and using the program as it takes away the fear factor.
- If you are working and learning remotely, do you have sufficient bandwidth to access the internet and run applications? If not, your employer may provide a high-speed router or an internet booster.
- Find a quiet place to engage in training. Eliminate distractions (eg, shut the door and post a sign that tells others in your household that you're "in training"). Make sure others know your schedule so that they don't inadvertently interrupt you.
- Beware of the temptation to multitask. Just because you aren't meeting in person doesn't mean you shouldn't be fully present.
- Take advantage of breaks to get up and move around when you can. This is one of the best things you can do to stay alert and refreshed.
- Most important, don't be afraid of technology. Anyone at any age or experience level can increase their tech-savviness, and training is the perfect way to do that.

An Added Benefit

In time, we will no doubt return to some in-person training when the need calls for it. Virtual training, however, will likely be part of the learning equation in the future. While virtual training changes how learning is delivered, it doesn't need to shortchange the human aspect of it.

continues on page 37

Sandra Zawalski, MSN, RN, CRRN, CCM, ABDA, MSCC, *is a commissioner and a past chair of the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies case managers. She is also a clinical educator and an independent case management consultant who specializes in assessing, developing, and implementing case management programs and case management training for providers and payers.*

Actual patient living with HIV.

EGRIFTA SV™
tesamorelin for injection

WHEN IT'S **HARD BELLY**

(EXCESS VISCERAL ABDOMINAL FAT)

IT MAY BE TIME FOR ***EGRIFTA SV™***

IF YOU ARE LIVING WITH HIV AND LIPODYSTROPHY ASK YOUR HEALTHCARE PROVIDER ABOUT *EGRIFTA SV™*.

FIND A SPECIALIST AT EGRIFTASV.COM

IMPORTANT INFORMATION FOR PATIENTS ABOUT *EGRIFTA SV™* (TESAMORELIN FOR INJECTION)

What is *EGRIFTA SV™* (tesamorelin for injection)?

- *EGRIFTA SV™* is an injectable prescription medicine used to reduce excess abdominal fat in adult patients living with HIV and lipodystrophy. *EGRIFTA SV™* is a growth hormone-releasing factor (GHRF) analog.
- *EGRIFTA SV™* is not for weight loss management.
- The long-term safety of *EGRIFTA SV™* **on the heart and blood vessels (cardiovascular) is not known**.
- It is not known whether taking *EGRIFTA SV™* helps improve how well you take your antiretroviral medications.
- It is not known if *EGRIFTA SV™* is safe and effective in children, do not use in children.

You should not take *EGRIFTA SV™* if you:

- Have a pituitary gland tumor, surgery, or other problems related to your pituitary gland, or have had radiation treatment to your head or head injury.
- Have active cancer.
- Are allergic to tesamorelin or any of the ingredients in *EGRIFTA SV™*.
- Are pregnant or become pregnant. If you become pregnant, stop using *EGRIFTA SV™* and talk with your healthcare provider.
- Are less than 18 years of age.

Before using *EGRIFTA SV™*, tell your healthcare provider if you:

- Have or have had cancer.
- Have problems with blood sugar or diabetes.
- Have scheduled heart or stomach surgery.
- Have breathing problems.
- Are breastfeeding or plan to breastfeed.
- Are taking any other prescription and non-prescription medicines, vitamins, and herbal supplements.

***EGRIFTA SV™* may cause serious side effects including:**

- **Increased risk of new cancer in HIV positive patients or your cancer coming back (reactivation).** Stop using *EGRIFTA SV™* if any cancer symptoms come back.
- **Increased levels of your insulin-like growth factor-1 (IGF-1).** Your healthcare provider will do blood tests to check your IGF-1 levels while you are taking *EGRIFTA SV™*.
- **Serious allergic reaction** such as rash or hives anywhere over the body or on the skin, swelling of the face or throat, shortness of breath or trouble breathing, fast heartbeat, feeling of faintness or fainting, itching and reddening or flushing of the skin. **If you have any of these symptoms, stop using *EGRIFTA SV™* and get emergency medical help right away.**
- **Swelling or fluid retention.** Call your healthcare provider if you have swelling, an increase in joint pain, or pain or numbness in your hands or wrist.
- **Increase in blood sugar (glucose) or diabetes.**
- **Injection site reactions.** Injection site reactions are a common side effect of *EGRIFTA SV™*, but may sometimes be serious.
- Increased risk of death in people who have critical illness because of heart or stomach surgery, trauma of serious breathing (respiratory) problems has happened when taking certain growth hormones.

The most common side effects of *EGRIFTA SV™* include:

- Pain in legs and arms
- Muscle pain

These are not all of the possible side effects of *EGRIFTA SV™*. For more information, ask your healthcare provider or pharmacist. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088 or to **THERA patient support™** toll-free at 1-833-23THERA (1-833-238-4372).

This information is not intended to replace discussions with your doctor. For additional information about *EGRIFTA SV™*, go to: www.egriftasv.com for the full Prescribing Information, Patient Information and Patient Instructions for Use, and talk to your doctor. For more information about *EGRIFTA SV™* contact **THERA patient support™** toll-free at 1-833-23THERA (1-833-238-4372).

THERA technologies

789-01-04/20 – 7,125x9.3125

Engaging Member Talent for a Brighter Future

Amy Black, *CMSA Executive Director*

While these past months have been challenging and offered many distractions, CMSA has been focused on the future of both the association and the case management profession. By bringing together community members representing diverse areas of thought, CMSA is preparing for a tomorrow that will offer additional support to progress your career and the field. As executive director of CMSA, I am impressed by the level of commitment and energy of both the volunteer leadership and the membership at large and look forward to working together to continue to build the future you deserve.

Here's what's been happening at CMSA:

Legacy Leaders Council

CMSA president, Melanie Prince, is bringing together the past presidents and leadership of CMSA on a quarterly basis to discuss the future of the association and the care manager profession. Having completed their first Coffee Connect in October 2020, it is clear that this group is committed, passionate, and perfectly combines historical and current perspectives with an eye towards innovation and out-of-the-box thinking. Their first meeting focused on the challenge of building a pipeline of leaders for both the association and the profession as well as the importance of creating a formalized mentoring program for both new and prospective case managers. More to come from this brain trust as they continue to meet and build upon their ideas and solutions.

Chapter Leaders' Coffee Connects

CMSA chapter leaders get together frequently to share best practices, tackle challenges, and work together for a stronger association. Led by the CMSA Chapter President's Council Chair, Danna Woolever, these informal networking discussions offer support to our valuable chapter leaders and a platform by which to learn, share, and grow. CMSA's success depends on the strength of the chapters; their work on the local level delivers relevant education and leads to valuable networking and critical advocacy, which helps drive the profession to new levels.

By bringing together community members representing diverse areas of thought, CMSA is preparing for a tomorrow that will offer additional support to progress your career and the field.

CMSA Partners

The great value that CMSA offers its membership is made possible by the generous support of the CMSA Partners. Partners are companies that recognize the importance of case managers in today's health care environment and offer a level of support that sustains our many programs and services throughout the entire year. This fall we welcomed two new 2021 Partners, 3M+KCI and Numotion. Please join us in thanking them and all of our CMSA Partners for their support!

CMSA Volunteers

The tireless work of our many volunteers allows CMSA to deliver relevant and valuable programs as well as information to both the membership and the profession. As a volunteer-led association, the membership sets the strategy, decides the vision and goals, and gives the association the direction and future outlook necessary to continue to elevate the profession. CMSA Committees drive membership; conceptualize and grow publications; develop and expand educational programs; direct the public policy priorities; plan an educational day for our military/Veteran Affairs/Department of Defense members; oversee the board nominations process and awards and recognize members for excellence; and, new this year, plan an engaging experience for those attending CMSA's first-ever hybrid annual conference in June 2021. The commitment is great, but the reward is greater. Consider supporting CMSA with your expertise, insight, and leadership!

National Case Management Week

What better way to engage the entire community of case managers than with a week-long celebration for National Case Management Week! October 11–17, 2020, was filled with celebrations, gratitude, relevant education, and a sense of

continues on page 32

***Amy Black** is executive director of the Case Management Society of America. She is an accomplished association executive, having worked for member-led organizations for over 20 years.*

COVID-19 Accommodations for Health Care Workers

Stan Scioscia, M.Ed., CDMS, CRC

Health care professionals in virtually all care settings must manage their risk of the novel coronavirus that causes COVID-19 as they interact with patients, patients' families/support systems, and even colleagues. The use of personal protection equipment, following social distancing guidelines, frequent handwashing, and other safety protocols help mitigate risk in most instances. In addition, many employers require online symptom surveys before any individual can access a worksite or business setting to prevent the virus from entering the environment.

Some health care professionals, however, have elevated risk factors as defined by the Centers for Disease Control and Prevention (see CDC guidelines). For these professionals, the existence of a medical condition that can be certified by a physician will likely lead them to pursue job accommodations or employment alternatives to further reduce their risk.

The easiest accommodation is to allow these employees to work virtually, which may be a viable option given the increase in telehealth in settings such as primary care, some aspects of acute care, and workers' compensation case management. For example, case managers may be able to deliver case management services to clients (known as patients in some settings) telephonically or via teleconference instead of in person.

In other practice settings and roles, however, virtual work and telehealth may not be an option. The next step for these case managers (and other health care professionals) who are at higher risk of complications due to COVID-19 is to pursue other job accommodations such as a temporary reassignment or transfer within their current employment setting. If they work for a large organization, these professionals

continues on page 33

Salute to Military and Veterans Affairs Case Managers

Melanie A Prince, Colonel USAF Retired, MSS, MSN, BSN, RN, NE-BC, CCM, FAA

Military and U.S. Department of Veterans Affairs (VA) case managers have important stories to tell! I had the distinct honor of serving in the U.S. Air Force for over 30 years, and now that I have transitioned to a civilian career, I realized the use of the terms U.S. Department of Defense (DOD) and VA can be somewhat confusing. As a salute to DOD (military) and VA case managers, I want to briefly explain some of the terminology. My expanding network of civilian colleagues will better understand how to navigate between the two systems as we clarify the terminology.

The DOD is similar to other federal agencies such as the U.S. Department of Homeland Security, U.S. Department of Health and Human Services, and the U.S. Department of Education. The DOD is responsible for providing military forces needed to deter war and protect the security of the nation. DOD beneficiaries represent patients/clients who are active duty or active reserve and their families who serve in the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, or U.S. Space Force. Case managers employed by the DOD may be active duty, federally employed civil servants, or contracted professionals.

Case management for those currently serving and for those who have served, including family members, is critical to achieve positive and cost-effective health outcomes. Professional case management practice is the same throughout both the U.S. Department of Defense and the U.S. Department of Veterans Affairs health care systems.

The VA is also similar to other federal agencies as listed above. The VA runs programs benefiting veterans and family members. A veteran is a person who has served in the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, or U.S. Space Force for at least 180 days and discharged under conditions that were other than dishonorable. Veteran and retiree are sometimes confusing terms. A veteran is not necessarily a military retiree (>180 days of service), but a military retiree is a veteran (>20 years of service). VA beneficiaries refer to patients/clients who are former members of the military and their families. Case managers employed by the VA may be civilian professionals who are federally employed civil servants or contracted health care professionals.

The health care systems in the DOD (military) and VA (postmilitary) are different systems. An easy way to remember the difference is to think of the beneficiaries as DOD = military members who are serving; VA = military members who have served.

One additional source of confusion lies with the TRICARE health insurance program for DOD (not VA) military (active, Guard, Reserve) members, retirees, and Medal of Honor recipients that provides coverage under several health care options. More information can be found at www.tricare.mil.

Two final terms: Military Health System (MHS) and Defense Health Agency (DHA). The MHS is the part of the DOD responsible for military health care. Further, Congress established the DHA in 2013 as an agency to integrate clinical and business processes across the MHS.

Case management for those currently serving and for those who have served, including family members, is critical to achieve positive and cost-effective health outcomes. Professional case management practice is the same throughout both DOD and VA

continues on page 37

Melanie A. Prince, MSS, MSN, BSN, RN, NE-BC, CCM, FAAN, *is president of the Case Management Society of America. Recently retired as an Air Force colonel, she is chief executive officer, Care Associates Consulting, and she is frequently asked to deliver presentations, editorials, and training on various case management and leadership topics. Melanie is a certified professional case manager and nurse executive, and she has master's degrees in nursing case management and military strategic studies.*

Resilience During Difficult Times

Christine M. MacDonell, FACRM

The Covid-19 pandemic has been a focusing event that has made all health and human service providers reflect upon current practices, focus on providing quality services in unique ways, and acknowledge that quality is still their focus even during challenging times. As case managers and companies providing case management services, resilience has been the word of the times. The Merriam-Webster Dictionary defines resilience as … "an ability to recover from or adjust easily to misfortune or change."

Resilience is necessary for the persons you serve, the organizations you work for, you as a health and human service provider, and society as a whole. What holds us up at these difficult times? Many believe that strong value systems serve as scaffolding during times of trouble.

It is important for all of us to examine our work and use the six domains of resilience to see if our scaffolding is strong enough to bring us out to the other side. The six domains are Vision, Composure, Reasoning, Health, Tenacity, and Collaboration. As an accreditor we reflect upon standards as foundational tools for organizations. In terms of resilience this article will walk through the standards and demonstrate that the six domains have a healthy presence in CARF standards.

We begin with **Vision,** which includes leadership, purpose, and goals. CARF considers part of the vision demonstrated by accredited organizations to be a person-centered philosophy that is practiced and demonstrated by both leadership and personnel. It is not just a phrase or words on a brochure but the purpose that guides the organization. With vision comes skills of balancing expectations, mitigating risks, maintaining a safe and healthy environment, developing and implementing a strategic plan, advocating for those you serve, and being a good citizen of the community you work with. At all times those with purpose, goals, and vision make themselves accessible to not only the persons they serve but to personnel and stakeholders as well.

Composure includes the ability to regulate emotions, interpret and understand bias, and to keep calm and in control of yourself and your business. To do this one must be clear about their scope and share that with those who would be interacting with case management. If one is not clear it is difficult to remain in control and calm. Being transparent with admission, transition, and discharge criteria for your services is essential. Being dynamic listeners of persons served, personnel, and stakeholders without bias is critical for success. Understanding diversity and cultural differences also leads to a better understanding of your work and those you serve.

Reasoning, the third domain, includes the skills of problem solving and being resourceful as well as anticipating and planning to deal with change. Change has occurred during this pandemic, and more change is to come. To be able to reason well you must have information that is complete, accurate, reliable, and valid. With financial information, risk management, and performance information a case manager or case

continues on page 37

Resilience is both necessary for the persons you serve, the organizations you work for, you as a health and human service provider, and society as a whole. It is important for all of us to examine our work and use the six domains of resilience to see if our scaffolding is strong enough to bring us out to the other side. The six domains are Vision, Composure, Reasoning, Health, Tenacity, and Collaboration.

Christine M. MacDonell, FACRM, *has served as the Managing Director of Medical Rehabilitation and Aging Services during her time with CARF. Chris has represented CARF International at international, national, regional, and local meetings to promote and interpret standards and the use of accreditation as a quality business and clinical strategy throughout the continuum of care. She is part of the medical rehabilitation team responsible for the training of CARF surveyors and the development and revision of CARF standards.*

Home Care Staff in New York City During the Pandemic

Elizabeth Hogue, Esq.

A recent article, "Experiences of Home Health Care Workers in New York City During the Coronavirus Disease 2019 Pandemic: A Qualitative Analysis" by Madeline R. Sterling, MD, MPH, MS et al, appeared in *JAMA Internal Medicine* online on August 4, 2020. The author describes a study conducted in partnership with the 1199SEIU Home Care Industry Education Fund. Participants included thirty-three home care workers employed by twenty-four different New York City agencies.

The study raised this question: "What are the experiences of home health care workers caring for older adults and for patients with chronic illnesses during the coronavirus disease 2019 (COVID-19) pandemic?" Home health and personal care aides and home attendants were interviewed. Participants reported that they were at greater risk for contracting and transmitting the coronavirus. Despite the fact that they provided integral care to vulnerable patients, home care staff involved in the study said that they felt inadequately supported and generally invisible.

Five major themes emerged:

1. Workers were on the front lines of the pandemic but felt invisible.
2. Staff members reported an increased risk for virus transmission.
3. Home care agencies provided various amounts of information, supplies, and training.
4. Participants relied on nonagency alternatives for support, including information and supplies.
5. Staff members were forced to make difficult trade-offs in their professional and personal lives.

Despite the fact that home health and personal care aides and home attendants provided integral care to vulnerable patients, home care staff involved in a study conducted in partnership with the 1199SEIU Home Care Industry Education Fund said that they felt inadequately supported and generally invisible.

Theme 1: On the Front Lines of COVID-19 Management, But Invisible

As essential workers, participants continued to work and care for their patients. Most patients had several chronic conditions that made them at high risk for contracting COVID-19. In addition to their usual tasks, workers monitored their patients for signs and symptoms of the coronavirus. Despite these important activities, many said that they felt invisible: "You hear people clapping, thanking doctors and nurses, even the hospital cleaning staff...I'm not doing this because I want praise; I love what I do. But it would be nice for people to show us gratitude."

Theme 2: Increased Risk for COVID-19 Transmission to Patients and Themselves

Participants worried about spreading the coronavirus to patients because workers routinely went to grocery stores and pharmacies on behalf of their patients. Those who usually took public transportation to work were also especially concerned about transmission of the virus to patients.

Theme 3: Varying Levels of Support from Agencies

Participants said they received varying levels of support from agencies they worked for when it came to: information about the coronavirus, availability of personal protective equipment (PPE), and training about how to care for COVID-19 patients.

Theme 4: Reliance on Alternative Sources for Support

When agencies did not provide the level of support that workers needed, they then turned to other sources, including the news media, social media, government briefings, the union, each other, and their faith.

Theme 5: Forced to Make Tough Trade-Offs Between Health and Finances

Workers had to decide whether to continue to care for coronavirus patients. Patients sometimes refused services, so workers then had to decide whether to take on new patients. Participants also had to decide whether to continue to see patients who they perceived as risky.

There is greater recognition that COVID-19 patients can, and perhaps should, receive care at home throughout the course of their illnesses. In order to succeed, staff members will be an essential part of the team. The issues described above must be addressed! CM

First, Do No Harm

Elizabeth Hogue, Esq.

"First, do no harm" is the primary directive for all healthcare practitioners. Achieving this goal at this time certainly requires vigilance, both personal and professional, on the part of all practitioners. Some commentators have suggested anecdotally that healthcare practitioners may be a significant vector of transmission of the coronavirus.

In an article in *The New York Times* on February 26, 2020, entitled "Shaved Heads, Adult Diapers: Life as a Nurse in the Coronavirus Outbreak," Nurse Zhang Wendan reported that she and her colleagues were required to live in the hospital where they worked for thirty consecutive days. They then quarantined for an additional fourteen days before returning home.

Likewise, Italian physicians raised the question in early reports about whether patients should be kept at home when diagnosed with coronavirus with intensive remote monitoring. They suggested that in-person care at home should be provided by a mobile team dedicated to the care of coronavirus patients and that only the most severely ill patients should be hospitalized.

In "Bringing the Hospital Home to Patients," by Gurvinder Kaur, MD, published on June 18, by Vituity, Dr. Kaur recommends that COVID-19 patients be kept at home whenever possible. The article provides details about how the "hospital at home" model has worked in a health system in California.

The questions of whether practitioners are a significant vector of transmission and if so, how to disrupt transmission will undoubtedly be resolved at some point in the future. In the meanwhile, practitioners must be vigilant about their conduct both on and off the job to help ensure that patients are not harmed. It's "all hands on deck" all of the time!

The questions of whether practitioners are a significant vector of transmission and if so, how to disrupt transmission will undoubtedly be resolved at some point in the future. In the meanwhile, practitioners must be vigilant about their conduct both on and off the job to help ensure that patients are not harmed. It's "all hands on deck" all of the time!

The importance of vigilance, both at work and in personal life, is underscored by a recent article in *The Boston Herald* on July 29, 2020. The article reported that thirteen patients and twenty-three employees at a Massachusetts hospital, Baystate Medical Center, tested positive for the coronavirus after an employee recently traveled to an out-of-state virus "hot spot." The situation was almost certainly exacerbated by the fact that hospital staff members gathered in break rooms without wearing masks or observing social distancing protocols.

Practitioners must be vigilant about their behavior at all times until more is known about how the coronavirus is transmitted, or until there is an available vaccine or treatment or both. In other words, it's not enough to wear personal protective equipment (PPE) and to adhere to infectious disease protocols at work in order to prevent harm to patients and colleagues. The current pandemic calls for more. Practitioners' conduct on and off the job may now cause harm to both patients and others. Be vigilant everywhere! CM

Elizabeth Hogue, Esquire, *is an attorney who represents health care providers. She has published 11 books, hundreds of articles, and has spoken at conferences all over the country.*

ETHICS CEU

Approved for 1 hour of CCM, CDMS, and nursing education ethics credit

CCM PACE™ Pre-Approved Continuing Education

Exam expires on December 15, 2021

Early Identification of and Care for Victims of Human Trafficking

Jeanine Zukerman, BSN, RN, CCM

Case managers are advocates who keep their clients safe and have empathy and a strong sense of responsibility. Predefined codes of ethics in our practice are set forth by state and professional regulatory boards (ie, nursing, social work) and are followed by CCMs (board-certified case managers), CDMSs (certified disability management specialists), and CRCs (certified rehabilitation counselors). We work to ensure the safety of those who cannot advocate for themselves: the mentally ill, illiterate, uninformed, intimidated, and fearful. Our profession is deemed to be the most honest and trusted profession in America. Case managers are uniquely qualified to identify, care for, and provide referrals for individuals with social, physical, mental, and health issues and to provide support services for victims of human trafficking. As health care professionals, we should familiarize ourselves with the laws and policies for mandatory reporting of human trafficking in our states. We also need to be aware of the reporting laws for minors.

In August 2018 I was first introduced to the horrors of human trafficking. I attended a mandatory continuing education presentation for RNs in Florida that was given by local law enforcement for our local CMSA (Case Management Society of America) chapter, and I learned that human trafficking occurs in Orlando. California and Texas rank first and second, respectively, in the nation for human trafficking, and my home state of Florida ranks third. I left that Saturday morning presentation with a burning sense of curiosity and embarrassment. At the time, I was working as a hospital emergency department case manager in a level one trauma hospital, and I had no idea how to identify and screen for victims of forced labor and sexual exploitation. To learn how I could help individuals who had been trafficked, I attended training sessions and I went to locations that I did not know existed in Central Florida. I met and traveled with human service volunteers, community rescue workers, and trauma-informed professionals. We visited migrant farm worker families in Immokalee and Apopka, we visited local strip clubs, and we volunteered in local safe houses for trafficked victims. I wanted to see and learn all I could about the crime of human trafficking, which is called "modern day slavery." Education, training sessions, and interviews with survivors made me recognize that trafficking can happen to anyone.

I asked myself the following questions. Did I unknowingly contribute to a trafficking situation by not being able to identify a crime? Why didn't I know what the appropriate action was for reporting suspicious or fraudulent activities? Did I ask if the victim if they needed or wanted help?

Trafficking is a Local Problem

All communities, whether urban or suburban, are vulnerable to human trafficking. Health care providers are one of a few professionals who are likely to interact with trafficked persons while they are still in captivity. Health care professionals should learn to spot the signs of human trafficking, and they are required to treat potential victims with respect and without judgement and discrimination by following the Code of Professional Conduct for Case Managers.

Every health care professional can and should be equipped to identify the physical and emotional signs of a trafficking victim. Health problems seen in victims of trafficking are commonly related to deprivation of food and sleep, extreme stress, movement through travel, violence (physical and sexual), and hazardous work environments.

Victims of trafficking who are United States (US) citizens are typically exploited through sex trafficking. Victims report that although they have met health care providers, they have not been identified as sex trafficking victims. Health care providers often do not have the necessary skills to screen and assist victims.

Human Trafficking is Highly Profitable

Human trafficking is a big business, with profits of approximately $150 billion a year[1]

- $99 billion from commercial sexual exploitation

Jeanine Zukerman, BSN, RN, CCM, *has vast experience in claims management with workers' compensation, hospital case management, managed care, vendor management, and utilization review. In her role at Paradigm, Jeanine uses her extensive experience both in care and case management to help each injured employee achieve the best outcome. Jeanine's interest in human trafficking prevention started with a mandatory awareness training for Florida RNs several years ago. She is now a passionate supporter of antihuman trafficking groups, and she continues to advocate for awareness, prevention, hope, and a healthy community.*

Every health care professional can and should be equipped to identify the physical and emotional signs of a trafficking victim. Health problems seen in victims of trafficking are commonly related to deprivation of food and sleep, extreme stress, movement through travel, violence (physical and sexual), and hazardous work environments.

- $34 billion from construction, manufacturing, mining and utilities
- $9 billion in agriculture, including forestry and fishing
- $8 billion dollars saved annually by private households that employ domestic workers under conditions of forced labor

A 2017 study by the *AMA Journal of Ethics*[2] showed that 88% of victims had contact with at least one health care professional during the period which they were being trafficked, yet *none* were offered help to get out of bondage. In addition, 63% of these victims reported that they were seen at an emergency department.

Trafficked persons have less access to health care services than other people because they are controlled and exploited. Many of the victims report their primary focus is on day-to-day survival. Many victims and survivors report use of minute clinics, urgent care centers, and emergency departments.

Health care facilities sometimes serve as the first and sometimes the only point of contact for trafficked individuals. Medical and social service providers have a unique opportunity to help and an ethical imperative to intervene in cases of human trafficking.

The American Hospital Association is partnering to develop programs to identify and respond to victims of human trafficking.

A human rights approach to trafficking means putting victims at the center of antitrafficking policies by prioritizing the protection of their rights.[3]

Human Trafficking—A Global Problem

All forms of human trafficking are motivated by money. An estimated $150 billion in profits are made globally every year. Traffickers use banks to deposit and launder earnings, and they use planes, buses, and taxi services for transportation. They book hotel rooms and use social media platforms to recruit and advertise.

According to The International Labour Organization, there are approximately 25 million victims of human trafficking around the world. Human trafficking is an issue for all countries and communities. Surprisingly, human trafficking does not necessarily involve the crossing of international borders. According to Polaris, trafficking has been reported in every state in the United States.

The Definition of Human Trafficking

The United Nations Definition of Human Trafficking Article 3(a) "*Trafficking in persons" shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery, or practices like slavery, servitude, or the removal of organs*[4]

According to the U.S. Department of State, human trafficking involves "*the act of recruiting, harboring, transporting, providing, or obtaining a person for compelled labor or commercial sex acts through the use of force, fraud or coercion.*"

Is it Trafficking?

Traffickers use force, fraud, or coercion to lure their victims and force them into labor or commercial sexual exploitation. It is not necessary to demonstrate force, fraud, or coercion in sex trafficking cases involving children under the age of 18**.**

6 Forms of Human Trafficking:

- **Forced Labor**
  Forced labor is when a person is forced to work in captivity with little or no pay. Forced labor is well documented in extractive industries—industries that consist of having children remove nonrenewable raw material out of the earth such as oil and minerals.
- **Sex Trafficking**
  Forcing, deceiving, or coercing a person to perform a commercial sex act. Sex trafficking can include forms of commercial sexual exploitation in sex tourism, pornography, and strip clubs.
- **Bonded Labor**
  Also known as debt bondage or peonage. Bonded labor is often made to look like an ordinary employment agreement at first, but in the agreement the worker starts with a debt to repay. This worker finds out later that this debt is impossible to repay, thus making their enslavement permanent.

Human trafficking victims are not always easy to spot. Many victims who have experienced physical and mental abuse do not believe that they are victims.

Workers may also inherit intergenerational or ancestral debt in more traditional systems of bonded labor.

- **Involuntary Servitude**
  Forcing a person to work and live in the same place for little or no pay. Involuntary domestic servitude consists of an individual working in a private residence.

  Domestic workers often are not given the same basic benefits and protections that are ordinarily bestowed upon workers.
- **Child Soldiers**
  Unlawful recruitment or use of children through force, fraud, or coercion as combatants or for labor or sexual exploitation by armed forces. Thousands of children, some as young as 8 years old, are currently serving as child soldiers around the world. These children are being forced into sexual slavery, are fighting on the front lines, are participating in suicide missions, and are acting as spies, messengers, or lookouts.

Trafficking Happens Everywhere

Nannies, maids, and domestic servants are forced to work in homes across the United States. Thousands of human trafficking cases are reported, but many more go unnoticed. Human trafficking is a hidden crime that is happening right in front of us. Victims are made to work for little or no pay. Human trafficking is the business of stealing freedom for profit. It is a multibillion-dollar criminal industry second only to drug dealing, and it denies freedom to millions of people around the world.

The U.S. Department of State estimates that between 14,000–17,000 people are trafficked in this country annually. According to Polaris, 49,000 cases of human trafficking have been reported to the National Human Trafficking Hotline in the last 10 years by phone calls and text messages.[5]

The top countries for human trafficking are India, China, Pakistan, and Thailand. In India, it is estimated that women and children make up 71% of India's bonded labor. Victims are denied their freedom and their livelihood and are commonly subjected to inhumane living and unsafe working conditions.

Who are Traffickers?

Traffickers can be family members or friends, and they can be any age, gender, ethnicity, or nationality.

What is Polaris?

Founded in 2002, Polaris is a nonprofit, nongovernmental organization that works to combat and prevent modern-day slavery and human trafficking. Work by Polaris is driven by the reports provided by victims and trafficking survivors. Polaris uses the data to fuel research, advocacy, and outreach projects for the antitrafficking movement. Polaris reports that "human trafficking is notoriously underreported."

Vulnerable Populations

Traffickers identify vulnerable populations and use them to create dependency. Vulnerable populations include recent immigrants, foreign nationals who are legally living and working in the United States, and individuals with substance use and mental health issues as well as runaways, homeless youth, and LGBQT populations. Children make up about 25% of the victims who are forced into labor and sexually exploited for commercial purposes. Research indicates that traffickers often recruit victims from drug rehabilitations centers as well as mental health and behavioral centers.

Health care professionals are learning to be first responders who can identify, treat, and refer potential victims. Public and private resources are used to train health care professionals about human trafficking. Learning how to approach every health care interaction from a trauma-informed perspective helps to reduce retraumatization. Screening and response protocols like the protocols used for domestic violence and child abuse can provide a framework.

Victims of trafficking can have a broad range of health issues including those affecting their sexual and reproductive health and mental health, and they can have on-the job injuries due to unsafe working conditions and substance abuse.

Clinicians who interact with trafficked persons will be more-effective health care professionals if they are respectful of their patients' wishes, sensitive to the complexity of their needs, and cognizant of factors that might have rendered them vulnerable to being trafficked in the first place (eg, child abuse and neglect).

Helpful Questions for Screening

- Can you leave your job if you want to?
- Can you come and go as you please?
- Have you or your family been threatened?
- What are your working and living conditions like?
- Where do you sleep and eat?

- Have you ever had sex for money?
- Do you have to ask permission to eat, sleep, or go to the bathroom?
- Are there locks on your doors and windows?
- Has your identification been taken away from you?

Screening tools and protocols are being developed by some hospital emergency departments to help identify trafficked victims. Human trafficking programs have only recently begun to be evaluated, and little is known about the most-effective approaches. Some organizations are building on their current domestic violence program to provide recommendations for human trafficking protocols.

Physical and Behavioral Signs of Human Trafficking to Look for in a Health Care Setting

- Musculoskeletal and ergonomic injuries
- Malnutrition/dehydration
- Lake of routine preventative care
- Poor dental hygiene
- Untreated skin infections
- Injuries or exposure to harmful chemicals and unsafe water
- Somatization
- Unexplained and conflicting stories
- Inability to speak without an interpreter
- Paranoid behavior
- Anxiety and panic attacks

COVID-19 and Human Trafficking

It is estimated that between 25%–30% of human trafficking victims are children.

With school closures and blocked access to education, shelter, and food, the United Nations (UN) estimates some 370 million students are currently missing meals and are thought to be living in precarious socioeconomic situations.

Lockdowns, travel restrictions, resource cutbacks, and other measures to curb the spread of the COVID-19 are putting victims at risk, and "drive-thru" services for child sexual exploitation have been spawned by COVID-19. Environmentally displaced people are a factor for the upsurge in human trafficking.

Sources from the UN[6] and Polaris tell us that COVID-19 is expected to expose more abuse as countries have closed their borders because of the pandemic. According to the United Nations Office on Drugs and Crime, the global trend of trafficking has shown an increase since 2010. Most victims of trafficking are from East Asia and subSaharan Africa.

Trafficking for sex exploitation is most common in European countries and in the United States. Women and girls make up most trafficking victims worldwide, with almost three-quarters of them trafficked for sexual exploitation. And 35% of women and girls are trafficked for forced labor.

A case manager's ability to establish a trusting relationship with the trafficking victim is critical. Training is necessary to help us learn how to connect victims with community resources that can help with their recovery.

Learning How to Help

Human trafficking affects every community in the nation, and victims—whether due to sex or labor trafficking—often turn to hospitals and health systems for care. These victims have complex needs.

Case managers and nurse are on the front line of care every day in emergency departments, health care clinics, and home health environments. Human trafficking victims are not always easy to spot. Many victims who have experienced physical and mental abuse do not believe that they are victims.

With proper training, case managers can learn to identify and assess suspected victims and understand how to administer trauma-informed care. Case managers who interact with trafficked persons will be more effective health care professionals if they are respectful of their patients' wishes, sensitive to the complexity of their needs, and cognizant of factors that may have made them vulnerable in the first place (eg, child abuse and neglect).

A case manager's ability to establish a trusting relationship with the trafficking victim is critical. Training is necessary to help us learn how to connect victims with community resources that can help with their recovery. Developing community partnerships with nonprofit and faith-based organizations is often a key component to helping the trafficked person. Community resources are needed to help provide shelter, counseling, and legal assistance. Social services and local government services can help to return victims back into the community. Not all victims are identified in the emergency department. Victims of human trafficking can be found in ambulatory care settings, community health centers, school health clinics, and private offices. Many smaller and rural hospitals have developed programs that can be duplicated in your community. It is important to be involved with community organizations, law enforcement, child protective services, faith-based organizations, and community and social services organizations.

Ethics of Reporting Human Trafficking

Health care professionals, who have to balance their role as mandatory reporters of human trafficking vs. the ethical obligation to "do no harm," may need to demonstrate the highest level of skill and knowledge to discern the best course of action. Case managers with specialty certifications such as CDMS and CCM have the highest level of knowledge of the law as well as the professional standards, ethics, and skills to recognize health and safety risks.

CDMS Ethics—Certified Disability Management Specialist

Principle 2: *Certified Disability Management Specialists shall respect the integrity and protect the welfare of those persons or groups with whom they are working.*

Principle 3: *Certified Disability Management Specialists shall always maintain objectivity in their relationships with clients.*

Principle 7: *Certified Disability Management Specialists shall obey all laws and regulations, avoiding any conduct or activity that could harm others.*

CCMC Code of Professional Conduct for Case Managers[7]

Scope of Practice for case managers

II. Underlying values

Belief that case management is a means for improving client health, wellness, and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. • Recognition of the dignity, worth, and rights of all people. • Understanding and commitment to quality outcomes for clients, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective. • Belief in the underlying premise that when the individual(s) reaches the optimum level of wellness and functional capability, everyone benefits: the individual(s) served, their support systems, the health care delivery systems, and the various reimbursement systems. • Recognition that case management is guided by the principles of autonomy, beneficence, nonmaleficence, and justice

Article IV

IV. Ethical Issues

Because case management exists in an environment that may look to it to solve or resolve various problems in the health care delivery and payor systems, case managers may often confront ethical dilemmas. Case managers must abide by the Code as well as by the professional code of ethics for their specific profession for guidance and support in the resolution of these conflicts.

If the trafficked patient is a child, it is required by law in all 50 states to report child abuse. If the trafficked patient is an

continues on page 34

CE Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on March 15, 2021

Shall We Dance? Conversations About Change

Rebecca Perez, MSN, RN, CCM

"How can we know the dancer from the dance?"
—William Butler Yeats

Dance is often considered a form of communication. The movements and rhythmic patterns of dance communicate and signify emotions and feelings. Think of the ballet "Swan Lake"; a story is told without language, but the story is understood, and emotions easily felt. Conversations can be like a dance—sometimes a step forward, then maybe a step back. Talking, listening, answering, making suggestions, and accepting or rejecting those suggestions indicate who may be leading and who may be following at any given time.

Communication is critical to life and is a necessity. As human beings, we need to express ourselves and our feelings, and we need to pass on to others information, thoughts, and emotions. To survive, we must communicate. Communication can be mechanical or merely the transmission of data from one person to another. But effective communication allows for the sharing of thoughts and feelings. How one communicates is part of the social interaction and determines how information is interpreted. Why this lesson in communication theory? There is a difference between content and relational dimensions of messaging, and in health care we are not always mindful of this. To be truly patient-centered, we must first pay attention to how we communicate, and we need to learn the dance of communication. The dance is motivational interviewing (MI).

For over 40 years, clinicians have been improving patient outcomes by incorporating MI in patient engagement and interaction. Originally developed and used to assist in the treatment of addiction, MI is now used in all health care settings and situations. MI is a nuanced form of communication that is simple but not easy, has many layers, and is not something learned with lectures and PowerPoint presentations. MI is a powerful patient-centered form of communication and counseling that increases the possibility a patient may consider and eventually implement behavioral changes. MI is a conversation about change.

Conversations about change can feel like a wrestling match. As health care professionals we want our patients to be well, and they will be well if they follow our instructions. When they don't follow or seem ambivalent about our instructions, we immediately want to launch into "patient education," which is a form of telling them what to do, all with the best intentions to "fix" the problem. Instead we should be asking what they know, what do they want to know, and what their challenges are.

MI teaches us to partner with our patients to listen, evoke, and support them. The decision to change is wholly theirs, not ours. As health care professionals, we cannot make anyone change, but we can engage in conversations that guide a patient to consider alternatives. According to Frost et al., MI has been shown to be effective in alcohol abuse treatment, smoking cessation, and increasing physical activity.[1] The National Institute for Health and Care Excellence (NICE) guidelines include MI as a component in effective interventions for behavior change strategies.[1] MI focuses on the language of change. How we ask for or say things is crucial to strengthening personal motivation to change by exploring the individual's reasons or lack of reason to commit. MI is ingrained in European primary care practices.[2] Providers incorporate MI into their patient visits scheduled four times per year.

"The only person who is educated is the one who has learned how to learn and change."
—Carl Rogers

For an individual to grow, they need an open environment that allows for self-disclosure and acceptance with unconditional positive regard and empathy.[3] Many of us need to make changes similarly to our patients. MI is a method that is particularly suited to those unsure about change or unwilling to change. Ambivalence about change is often seen as an obstacle when, in fact, it is an opportunity. Ambivalence is a

Rebecca Perez, MSN, RN, CCM, *has a master's degree in nursing with specialization in care coordination and is a Certified Case Manager with extensive clinical and case management experience. She has been involved with the Case Management Society of America (CMSA) since 1997, holding both local and national leadership positions, and was honored with the 2013 National CMSA Case Manager of the Year award. She has recently moved into the position of Senior Manager of Education and Strategic Partnerships for Parthenon Management Group (PMG).*

To be truly patient-centered, we must first pay attention to how we communicate, and we need to learn the dance of communication. The dance is motivational interviewing.

typical human experience, and if we can help our patients explore their hesitancy, resistance can be minimized and motivation to change can be maximized.[3]

The primary goal of case management is to guide a patient to a point where they can self-manage and function autonomously. Change is more likely to occur when three basic needs are met: the ability to make decisions, having a sense of competency and mastery, and feeling supported.[3] The behavior of health care professionals also plays a role in the patient's willingness to consider change. We must demonstrate positivity by avoiding disagreement and confrontation. We must work to engage our patients so that they become active participants in their care. What can be most difficult for health care professionals is refraining from judgment, advising without permission, and understanding that ambivalence is a normal part of the change process.

Learning the dance steps: the skillset

There are four communication techniques used in MI:

1. Open-ended questions
2. Affirming
3. Reflective listening
4. Summarizing

Open-ended questions create and support the continuance of conversations and are crucial to building a collaborative relationship. These types of items are most useful in exploring the patient's openness to change.

Affirmations recognize the patient's strengths and abilities. Building rapport and validating emotions are well-known coaching techniques that are supported by affirming statements.

Reflective listening is a technique to ensure that what the patient has said is accurately heard and understood. Repeating what the patient has said as a statement rather than a question encourages them to keep talking. Reflective listening occurs as a part of summarizing. We should summarize every encounter to not only validate what was heard but also to reinforce the discussion and any takeaways. Individuals only recall 30% of a conversation, and thus summarizing increases the retention of what was discussed.

"People are better persuaded by the reasons they themselves discovered than those that come into the minds of others."
—Blaise Pascal

So, you think you can dance?

Case study for MI practice

Here is an opportunity to reflect on your MI skills. Review the case study and think about how you would interact and communicate in this particular situation.

Lorraine is a 62-year old widow with a 10-year history of type 2 diabetes. She has been prescribed an 1800 calorie American Diabetes Association diet and has taken metformin and atorvastatin for the last 5 years. She is the general manager of a grocery store that is part of a regional chain. Her job requires long hours and occasional weekends. Chelsea, Lorraine's daughter, got divorced recently and she and her two children (aged 6 years and 9 years) have recently moved into Lorraine's home. Chelsea is a licensed practical nurse at a long-term care facility and works three 12-hour shifts per week. Lorraine stays with the children during the evening hours when Chelsea is working.

Lorraine is visiting her primary care physician on a quarterly basis. Her HbA1c is 9%, up from 8.5% 3 months ago. She brings her home glucose log, which reveals inconsistency in testing and blood sugar readings between 173 and 230 mg/dL. These findings are shared with Lorraine, and she is asked for her thoughts.

"You know, I am even busier than ever now that Chelsea and the kids have moved in. Don't get me wrong. I love having them there, and I feel good about being able to help Chelsea, but life is much more hectic. And to add insult to injury, two of my employees are out on the Family and Medical Leave Act, which leaves the store short-staffed. I know my blood sugar isn't where it's supposed to be, but I don't feel bad. And I know I am supposed to be trying to exercise three times per week, but I just can't seem to find the time. I am picking up fast food for dinner so that the kids have something to eat and can get their homework done before it gets too late in the evening. I am too tired to cook and there just doesn't seem to be enough hours in the day."

How would you respond?

1. "Your blood sugar is too high and if you don't get it down you could have a heart attack or stroke."
2. "You sound very busy, but you need to lower your blood sugar. Do you know what happens when your blood sugar stays too high? Well let me tell you…."

Motivational interviewing is a powerful patient-centered form of communication and counseling that increases the possibility a patient may consider and eventually implement behavioral changes. Motivational interviewing is a conversation about change.

3. "So, let's talk about diabetes. Do you know what the complications of high blood sugar are? You say you don't feel bad, but how do you feel when your blood sugar is normal? You are eating a lot of fast food, which isn't healthy. Let's refer you to a dietician."

If you would have responded with any of these choices or with similar statements, you need more dance lessons.

How should you respond?

Not one of those responses was delivered in the spirit of MI. MI should come from a place of acceptance, empathy, evocation, and partnership. Lorraine does not need to be scolded like a naughty child, and she does not need to be told what to do. Lorraine needs to have an opportunity to explore her situation and together with her health care provider find a way to have self-management skills that work with her situation. So instead of launching into diabetes disease education or shaming and blaming, the following is an example of the spirit of MI.

"My goodness Lorraine, you are one busy lady! And I must say I admire your commitment to your daughter and grandchildren. It must be difficult to manage your schedule and theirs."

These statements are open-ended and will allow Lorraine to share more about her situation.

"Lorraine would you mind telling me about a typical day?"

Again, you are eliciting more information before giving information. It's always best to know more before you share more.

"Wow, Lorraine, that is a really busy day. Can you think of anything that you do that could maybe become a lower priority?"

This will help Lorraine think critically about her activities.

"What are your priorities? What must take place every day for you to feel comfortable and accomplished?"

Now we are asking her to think about what is important.

"So, Lorraine, you have shared a lot with me, and I feel I understand you a bit better. Would it be OK if I made some suggestions that might help with your challenges and then you can take time to think about them? You are taking your medicine, and that is a good step, but maybe we can come up with some solutions that will help support your other diabetes management efforts. What do you think?

Some of you are thinking that you don't have time for lengthy conversations. Consider that the above conversation would take no more than 10 minutes. If this conversation does not occur, you will likely see Lorraine in 3 months with an even higher HbA1c and perhaps other side effects. Once you are more comfortable with the skills and the method, these conversations become effortless. You will not need MI for every patient encounter, but for those that need to make changes, learning to be proficient will not only improve health outcomes but will make you much more effective because you are efficiently communicating.

Why do I need to learn to dance? What's in it for me?

Becoming better communicators is ultimately more important than all of the scientific breakthroughs in health and medicine. Regardless of illness, condition, or injury, we are working with human beings, and our positive interactions with them will result in improved health outcomes. Many health care practitioners have attended a workshop or presentation on MI and consider themselves "trained." In reality, if the method is not incorporated into your daily practice and you are not seeing your patients making changes, your proficiency is questionable. The following are statements from case managers who realized the importance of MI training and integration into how they communicate. They discovered the "what's in it for me" (WIIFM) and committed to becoming proficient with MI through learning and practice.

"A recent career experience taught me that, despite over 20 years of teaching, counseling, and interviewing patients/clients to optimize their health status and promote health-seeking behaviors, I was woefully inadequate in MI. I was working with survivors of sexual assault and felt confident that my communication skills would lead to active engagement in the survivors' treatment and recovery plan, pursuit of justice, and development of long-term coping skills. I was wrong. I was unprepared to overcome the ambivalence, insecurities, fear, and self-preservation that were some of the barriers to motivating survivor

As health care professionals, we cannot make anyone change, but we can engage in conversations that guide a patient to consider alternatives.

engagement. I wished I had the knowledge, skills, and abilities of a professional trained in MI techniques that would have supported my clients in a more successful way. MI requires training and practice to achieve client-centered success in behavioral changes necessary for improved quality of life."

—Melanie Prince, MSS, MSN, BSN, RN, NE-BC, CCM, FAAN, CMSA President, 2020–2022

"I had contact with a young woman who my son knew from the community, or I should say from the subculture of those with the disease of addiction. I was driving my son to his apartment and this young woman who was known to me was walking along the road carrying a shopping bag. She was homeless and had clearly relapsed. John asked me to stop and give her a ride. I stopped and we all went to the local diner. I made her put out her cigarette out before getting into my car....lol.

I applied the first core value of MI of being accepting, nonjudgmental, and respectful, and I was able to quickly establish in a conversation that increased trust.

As we sat across from each other in a booth, I asked a simple open-ended question that led to an intense conversation. "What are your days like since you no longer have a safe place to live?" Her response was long and tearful as she described all that had been lost.

Responding with empathy to her response, I moved on and decided to use the "look over the fence" strategy. I asked her "what she thought her life would be like without using drugs?" Although ambivalent about treatment, she agreed to allow me to take her to a local clinic in the area that would assist her. Although her story continued, this MI encounter was the first step of her successful treatment.

I feel that one of the most important introductions to the use of MI strategies is to learn how to establish and build trust in the initial patient engagement. It can be difficult at first for some case managers when working with patients with addiction, but it is critical to a good outcome."

—Sheilah McGlone, RN, CCM, independent consultant and educator

The final bow/curtsy

Partnership is essential to the development of trusted relationships, and MI supports that development with the give and take in conversations. Partnerships are like dancing: learning to move in sync takes effort and practice. We may step on each other's toes from time to time, but eventually that happens less and less. Consider honing your skills with additional reading or taking an MI course that includes teach-back or other resources that will sharpen your skills. To learn to dance, lessons are required or you need instruction from an expert. No one wakes up one day to dance the tango—it takes instruction and practice. Find your expert, spend time reading and learning, and you will soon be dancing the dance of MI. CE II

Suggested Reading

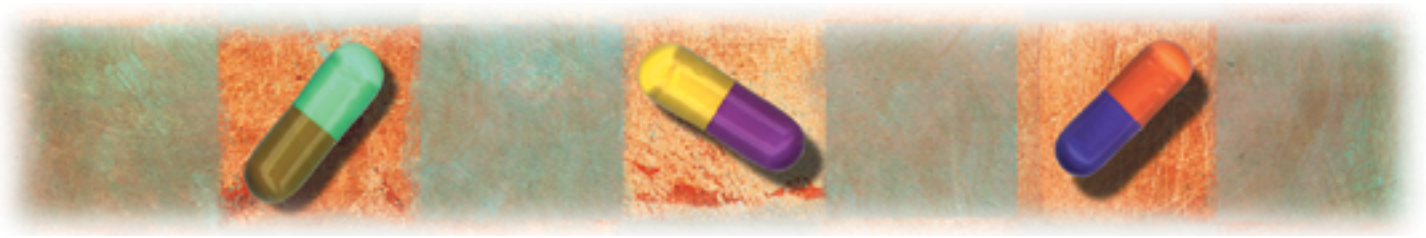
Berger B, Villaume W. *Motivational Interviewing for Health Care Professionals: A Sensible Approach.* 2nd ed. Washington, DC; American Pharmacists Association; 2020.

Rollnick S, Mason P, Butler C. *Health Behavior Change: A Guide for Practitioners.* Edinburgh; Churchill Livingstone; 2006.

References

1. Frost H, Campbell P, Maxwell M, et al. Effectiveness of motivational interviewing on adult behaviour change in health and social care settings: a systematic review of reviews. *PLoS One.* 2018;13(10):e0204890. Published Oct 18 2018. doi:10.1371/journal.pone.0204890
2. Oberink R, Boom SM, van Dijk N, Visser MRM. Assessment of motivational interviewing: a qualitative study of response process validity, content validity and feasibility of the motivational interviewing target scheme (MITS) in general practice. *BMC Med Educ.* 2017;17(1):224. Published Nov 21 2017. doi:10.1186/s12909-017-1052-7.
3. Souders B. PositivePsychology.com. Motivational interviewing questions and skills. https://positivepsychology.com/motivational-interviewing/

PharmaFacts for Case Managers



Veklury® (remdesivir) for injection, for intravenous use

INDICATIONS AND USAGE

Veklury is indicated for adults and pediatric patients (12 years of age and older and weighing at least 40 kg) for the treatment of coronavirus disease 2019 (COVID-19) requiring hospitalization. Veklury should only be administered in a hospital or in a healthcare setting capable of providing acute care comparable to inpatient hospital care.

DOSAGE AND ADMINISTRATION

Testing Before Initiating and During Treatment with Veklury

Determine eGFR in all patients before starting Veklury and monitor while receiving Veklury as clinically appropriate.

Perform hepatic laboratory testing in all patients before starting Veklury and while receiving Veklury as clinically appropriate.

Determine prothrombin time in all patients before starting Veklury and monitor while receiving Veklury as clinically appropriate.

Recommended Dosage in Adults and Pediatric Patients 12 Years of Age and Older and Weighing at Least 40 kg

The recommended dosage for adults and pediatric patients 12 years of age and older and weighing at least 40 kg is a single loading dose of Veklury 200 mg on Day 1 via intravenous infusion followed by once-daily maintenance doses of Veklury 100 mg from Day 2 via intravenous infusion.

- The recommended treatment duration for patients not requiring invasive mechanical ventilation and/or extracorporeal membrane oxygenation (ECMO) is 5 days. If a patient does not demonstrate clinical improvement, treatment may be extended for up to 5 additional days for a total treatment duration of up to 10 days.
- The recommended total treatment duration for patients requiring invasive mechanical ventilation and/or ECMO is 10 days.
- Veklury must be diluted prior to intravenous infusion.

Renal Impairment

Veklury is not recommended in patients with eGFR <30 mL per minute.

Dose Preparation and Administration

- Veklury must be prepared and administered under the supervision of a healthcare provider.
- Veklury must be administered via intravenous infusion only. Do not administer by any other route.
- Veklury is available in two dosage forms:
  - Veklury for injection (supplied as 100 mg lyophilized powder in vial) needs to be reconstituted with Sterile Water for Injection prior to diluting in a 100 mL or 250 mL 0.9% sodium chloride infusion bag.
  - Veklury injection (supplied as 100 mg/20 mL [5 mg/mL] solution in vial) must be diluted in a 250 mL 0.9% sodium chloride infusion bag.
- Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration. Discard the vial if the lyophilized powder or solution is discolored or contains particulate matter. Prior to dilution in a 0.9% sodium chloride infusion bag, reconstituted Veklury for injection and Veklury injection solution should be a clear, colorless to yellow solution, free of visible particles.
- Prepare diluted solution under aseptic conditions and on same day as administration.

Veklury for Injection (Supplied as 100 mg Lyophilized Powder in Vial)

Reconstitution Instructions

Remove the required number of single-dose vial(s) from storage. For each vial:

- Aseptically reconstitute Veklury lyophilized powder by adding 19 mL of Sterile Water for Injection using a suitably sized syringe and needle per vial.
- Only use Sterile Water for Injection to reconstitute Veklury lyophilized powder.
- Discard the vial if a vacuum does not pull the Sterile Water for Injection into the vial.
- Immediately shake the vial for 30 seconds.
- Allow the contents of the vial to settle for 2 to 3 minutes. A clear solution should result.
- If the contents of the vial are not completely dissolved, shake the vial again for 30 seconds and allow the contents to settle for 2 to 3 minutes. Repeat this procedure as necessary until the contents of the vial are completely dissolved. Discard the vial if the contents are not completely dissolved.

- Following reconstitution, each vial contains 100 mg/20 mL (5 mg/mL) of remdesivir solution.
- Use reconstituted product immediately to prepare the diluted drug product.

Dilution Instructions

Care should be taken during admixture to prevent inadvertent microbial contamination.

As there is no preservative or bacteriostatic agent present in this product, aseptic technique must be used in preparation of the final parenteral solution. It is always recommended to administer intravenous medication immediately after preparation when possible.

Withdraw and discard the required volume of 0.9% sodium chloride from the bag, using an appropriately sized syringe and needle.

- Withdraw the required volume of reconstituted Veklury for injection from the Veklury vial, using an appropriately sized syringe. Discard any unused portion remaining in the reconstituted vial.
- Transfer the required volume of reconstituted Veklury for injection to the selected infusion bag.
- Gently invert the bag 20 times to mix the solution in the bag. Do not shake.
- The prepared infusion solution is stable for 24 hours at room temperature (20°C to 25°C [68°F to 77°F]) or 48 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]).

Administration Instructions

Do not administer the prepared diluted solution simultaneously with any other medication. The compatibility of Veklury injection with intravenous solutions and medications other than 0.9% sodium chloride injection, USP is not known. Administer Veklury via intravenous infusion over 30 to 120 minutes.

- Reconstituted Veklury for injection, containing 100 mg/20 mL remdesivir solution, must be further diluted in either a 100 mL or 250 mL 0.9% sodium chloride infusion bag.

Veklury Injection (Supplied as 100 mg/20 mL [5 mg/mL] Solution in Vial)

Dilution Instructions

Care should be taken during admixture to prevent inadvertent microbial contamination.

As there is no preservative or bacteriostatic agent present in this product, aseptic technique must be used in preparation of the final parenteral solution. It is always recommended to administer intravenous medication immediately after preparation when possible.

Remove the required number of single-dose vial(s) from storage. Each vial contains 100 mg/20 mL of remdesivir. For each vial:

- Equilibrate to room temperature (20°C to 25°C [68°F to 77°F]). Sealed vials can be stored up to 12 hours at room temperature prior to dilution.
- Inspect the vial to ensure the container closure is free from defects and the solution is free of particulate matter.
- Veklury injection must be diluted in an infusion bag containing 250 mL of 0.9% **sodium chloride only.**
  - Withdraw and discard the required volume of 0.9% sodium chloride from the bag, using an appropriately sized syringe and needle.
- Withdraw the required volume of Veklury injection from the Veklury vial, using an appropriately sized syringe.
- Pull the syringe plunger rod back to fill the syringe with approximately 10 mL of air.
- Inject the air into the Veklury injection vial above the level of the solution.
- Invert the vial and withdraw the required volume of Veklury injection solution into the syringe. The last 5 mL of solution requires more force to withdraw.
- Transfer the required volume of Veklury injection to the infusion bag.
- Gently invert the bag 20 times to mix the solution in the bag. Do not shake.
- The prepared infusion solution is stable for 24 hours at room temperature (20°C to 25°C [68°F to 77°F]) or 48 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]).

Administration Instructions

Do not administer the prepared diluted solution simultaneously with any other medication. The compatibility of Veklury injection with intravenous solutions and medications other than 0.9% sodium chloride injection, USP is not known. Administer Veklury via intravenous infusion over 30 to 120 minutes.

Storage of Prepared Dosages

Veklury for Injection (Supplied as Lyophilized Powder in Vial)

After reconstitution, use vials immediately to prepare diluted solution. The diluted Veklury solution in the infusion bags can be stored up to 24 hours at room temperature (20°C to 25°C [68°F to 77°F]) prior to administration or 48 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]).

Veklury Injection (Supplied as Solution in Vial)

Store Veklury injection after dilution in the infusion bags up to 24 hours at room temperature (20°C to 25°C [68°F to 77°F]) or 48 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]).

IMPORTANT:

This product contains no preservative. Any unused portion of a single-dose Veklury vial should be discarded after a diluted solution is prepared.

DOSAGE FORMS AND STRENGTHS

- Veklury for injection, 100 mg, available as a sterile, preservative-free white to off-white to yellow lyophilized powder in single-dose vial for reconstitution.
- Veklury injection, 100 mg/20 mL (5 mg/mL), available as a clear, colorless to yellow solution, free of visible particles in single-dose vial.

CONTRAINDICATIONS

Veklury is contraindicated in patients with a history of clinically significant hypersensitivity reactions to Veklury or any components of the product.

WARNINGS AND PRECAUTIONS

Hypersensitivity Including Infusion-Related and Anaphylactic Reactions

Hypersensitivity reactions, including infusion-related and anaphylactic reactions, have been observed during and following administration of Veklury. Signs and symptoms may include hypotension, hypertension, tachycardia, bradycardia, hypoxia, fever, dyspnea, wheezing, angioedema, rash, nausea, diaphoresis, and shivering. Slower infusion rates, with a maximum infusion time of up to 120 minutes, can be considered to potentially prevent these signs and symptoms. Monitor patients under close medical supervision for hypersensitivity reactions during and following administration of Veklury. If signs and symptoms of a clinically significant hypersensitivity reaction occur, immediately discontinue administration of Veklury and initiate appropriate treatment. The use of Veklury is contraindicated in patients with known hypersensitivity to Veklury or any components of the product.

Increased Risk of Transaminase Elevations

Transaminase elevations have been observed in healthy volunteers who received 200 mg of Veklury followed by 100 mg doses for up to 10 days; the transaminase elevations were mild (Grade 1) to moderate (Grade 2) in severity and resolved upon discontinuation of Veklury. Transaminase elevations have also been reported in patients with COVID-19 who received Veklury. Because transaminase elevations have been reported as a clinical feature of COVID-19, and the incidence was similar in patients receiving placebo versus Veklury in clinical trials of Veklury, discerning the contribution of Veklury to transaminase elevations in patients with COVID-19 can be challenging. Perform hepatic laboratory testing in all patients before starting Veklury and while receiving Veklury as clinically appropriate.

- Consider discontinuing Veklury if ALT levels increase to >10 times the upper limit of normal.
- Discontinue Veklury if ALT elevation is accompanied by signs or symptoms of liver inflammation.

Risk of Reduced Antiviral Activity When Coadministered with Chloroquine Phosphate or Hydroxychloroquine Sulfate

Coadministration of Veklury and chloroquine phosphate or hydroxychloroquine sulfate is not recommended based on cell culture data demonstrating an antagonistic effect of chloroquine on the intracellular metabolic activation and antiviral activity of Veklury.

ADVERSE REACTIONS

The following adverse reactions were observed in clinical trials:

- Hypersensitivity including infusion-related and anaphylactic reactions
- Increased risk of transaminase

Less Common Adverse Reactions

Clinically significant adverse reactions that were reported in <2% of subjects exposed to Veklury in clinical trials are listed below:

Hypersensitivity reactions

- Generalized seizure
- Rash

DRUG INTERACTIONS

Due to antagonism observed in cell culture, concomitant use of Veklury with chloroquine phosphate or hydroxychloroquine sulfate is not recommended.

Drug-drug interaction trials of Veklury and other concomitant medications have not been conducted in humans. Remdesivir and its metabolites are in vitro substrates and/or inhibitors of certain drug metabolizing enzymes and transporters. The clinical relevance of these in vitro assessments has not been established.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

Available data from published case reports and compassionate use of remdesivir in pregnant women are insufficient to evaluate for a drug-associated risk of major birth defects, miscarriage, or adverse maternal or fetal outcomes. In nonclinical reproductive toxicity studies, remdesivir demonstrated no adverse effect on embryo-fetal development when administered to pregnant animals at systemic exposures (AUC) of the predominant circulating metabolite of remdesivir (GS-441524) that were 4 times (rats and rabbits) the exposure in humans at the recommended human dose (RHD).

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

Clinical Considerations

Disease-associated maternal and/or embryo-fetal risk

Pregnant women hospitalized with COVID-19 are at risk for serious morbidity and mortality.

Lactation

Risk Summary

There are no available data on the presence of remdesivir in human milk, the effects on the breastfed infant, or the effects on milk production. In animal studies, remdesivir and metabolites have been detected in the nursing pups of mothers given remdesivir, likely due to the presence of remdesivir in milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Veklury and any potential adverse effects on the breastfed child from Veklury or from the underlying maternal condition. Breastfeeding

individuals with COVID-19 should follow practices according to clinical guidelines to avoid exposing the infant to COVID-19.

Pediatric Use

The safety and effectiveness of Veklury for the treatment of COVID-19 have been established in pediatric patients 12 years and older and weighing at least 40 kg. Use in this age group is based on extrapolation of pediatric efficacy from adequate and well-controlled studies in adults.

Clinical trials of Veklury included 30 adult subjects weighing 40-50 kg. The safety in this weight group was comparable to adult subjects weighing >50 kg. Thirty-nine pediatric patients 12 years and older and weighing at least 40 kg received Veklury in a compassionate use program; the available clinical data from these patients are limited.

All pediatric patients 12 years of age and older and weighing at least 40 kg must have eGFR determined before starting Veklury and while receiving Veklury as clinically appropriate.

The safety and effectiveness of Veklury have not been established in pediatric patients <12 years of age or weighing <40 kg.

Geriatric Use

Reported clinical experience has not identified differences in responses between the elderly and younger patients. No dosage adjustment is required in patients over the age of 65 years. In general, appropriate caution should be exercised in the administration of Veklury and monitoring of elderly patients, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

Renal Impairment

The pharmacokinetics of Veklury have not been evaluated in patients with renal impairment. Patients with eGFR ≥30 mL per minute have received Veklury for treatment of COVID-19 with no dose adjustment of Veklury.

All patients must have an eGFR determined before starting Veklury and while receiving Veklury as clinically appropriate. Because the excipient betadex sulfobutyl ether sodium is renally cleared and accumulates in patients with decreased renal function, administration of drugs formulated with betadex sulfobutyl ether sodium (such as Veklury) is not recommended in patients with eGFR <30 mL per minute.

Hepatic Impairment

The pharmacokinetics of Veklury have not been evaluated in patients with hepatic impairment.

Perform hepatic laboratory testing in all patients before starting Veklury and while receiving Veklury as clinically appropriate.

CLINICAL STUDIES

NIAID ACTT-1 Study in Subjects with Mild/Moderate and Severe COVID-19

A randomized, double-blind, placebo-controlled clinical trial (ACTT-1, NCT04280705) of hospitalized adult subjects with confirmed SARS-CoV-2 infection and mild, moderate, or severe COVID-19 compared treatment with Veklury for 10 days (n=541) with placebo (n=521). Mild/moderate disease was defined as SpO2 >94% and respiratory rate <24 breaths/minute without supplemental oxygen; severe disease was defined as an SpO2 ≤94% on room air, a respiratory rate ≥24 breaths/minute, an oxygen requirement, or a requirement for mechanical ventilation. Subjects had to have at least one of the following to be enrolled in the trial: radiographic infiltrates by imaging, SpO2 ≤94% on room air, a requirement for supplemental oxygen, or a requirement for mechanical ventilation. Subjects treated with Veklury received 200 mg on Day 1 and 100 mg once daily on subsequent days, for 10 days of treatment via intravenous infusion. Treatment with Veklury was stopped in subjects who were discharged from the hospital prior to the completion of 10 days of treatment.

At baseline, mean age was 59 years (with 36% of subjects aged 65 or older); 64% of subjects were male, 53% were White, 21% were Black, and 13% were Asian; 24% were Hispanic or Latino; 105 subjects had mild/moderate disease (10% in both treatment groups); 957 subjects had severe disease (90% in both treatment groups). A total of 285 subjects (27%) (n=131 received Veklury) were on invasive mechanical ventilation or ECMO. The most common comorbidities were hypertension (51%), obesity (45%), and type 2 diabetes mellitus (31%); the distribution of comorbidities was similar between the two treatment groups.

The primary clinical endpoint was time to recovery within 29 days after randomization. Recovery was defined as discharged from the hospital without limitations on activities, discharged from the hospital with limitations on activities and/or requiring home oxygen, or hospitalized but not requiring supplemental oxygen and no longer requiring ongoing medical care. The median time to recovery was 10 days in the Veklury group compared to 15 days in the placebo group (recovery rate ratio 1.29 [95% CI 1.12 to 1.49], p<0.001). Among subjects with mild/moderate disease at enrollment (n=105), the median time to recovery was 5 days in both the Veklury and placebo groups (recovery rate ratio 1.22 [95% CI 0.82 to 1.81]). Among subjects with severe disease at enrollment (n=957), the median time to recovery was 11 days in the Veklury group compared to 18 days in the placebo group (recovery rate ratio 1.31 [95% CI 1.12 to 1.52]).

A key secondary endpoint was clinical status on Day 15 assessed on an 8-point ordinal scale consisting of the following categories:

1. not hospitalized, no limitations on activities;
2. not hospitalized, limitation on activities and/or requiring home oxygen;
3. hospitalized, not requiring supplemental oxygen—no longer requires ongoing medical care;
4. hospitalized, not requiring supplemental oxygen—requiring ongoing medical care (COVID-19 related or otherwise);
5. hospitalized, requiring supplemental oxygen;
6. hospitalized, on noninvasive ventilation or high-flow oxygen devices;

continued on page 35

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.

J Acquir Immune Defic Syndr. 2020 Dec 1;85(4):436-443. doi: 10.1097/QAI.0000000000002478.

Economic burden among gay, bisexual, and other men who have sex with men living with HIV or living without HIV in the multicenter AIDS cohort study

Dean LT, Nonyane BAS, Ugoji C, et al.

BACKGROUND: With HIV now considered a chronic disease, economic burden for people living with HIV (LWH) may threaten long-term disease outcomes. We studied associations between economic burden (employment, income, insurance, and financial difficulty) and HIV status for gay, bisexual, and other men who have sex with men (GBMSM) and how economic burden relates to disease progression.

SETTING: We analyzed data collected every 6 months through 2015 from GBMSM LWH and GBMSM living without HIV from 2 waves (2001-2003 cohort and 2010+ new recruit cohort) of the Multicenter AIDS Cohort Study.

METHODS: Using generalized estimating equations, we first assessed the association between HIV status (exposure) and economic burden indicators since the last study visit (outcomes) of employment (working/student/retired versus not currently working), personal annual income of ≥$10,000, insurance (public/private versus none), and financial difficulty meeting basic expenses. Then among people LWH, we assessed the relationships between economic burden indicators (exposures), risk of progressive immune suppression (CD4 ≤500 cells/μL), and progression to AIDS (CD4 ≤200; outcomes).

RESULTS: Of 1721 participants, 59.5% were LWH (n = 1024). GBMSM LWH were 12% less likely to be employed, 16% more likely to have health insurance, and 9% more likely to experience financial difficulty than GBMSM living without HIV. Among GBMSM LWH, employment was associated with a 6% and 32% lower likelihood of immune suppression or progression to AIDS, respectively, and the income was associated with a 15% lower likelihood of progression to AIDS.

CONCLUSIONS: Interventions that stabilize employment, income, and offer insurance support may enrich GBMSM LWH's ability to prevent disease progression.

J Acquir Immune Defic Syndr. 2020 Oct 28. doi: 10.1097/QAI.0000000000002556. Online ahead of print.

Weight gain following antiretroviral therapy (ART) initiation in ART-naïve people living with HIV in the current treatment era

Ruderman SA, Crane HM, Nance RM, et al.

OBJECTIVES: Evaluate differences in weight change by regimen among people living with HIV (PLWH) initiating antiretroviral therapy (ART) in the current era.

METHODS: Between 2012-2019, 3232 ART-naïve PLWH initiated >3-drug ART regimens in eight Centers for AIDS Research Network of Integrated Clinical Systems (CNICS) sites. We estimated weight change by regimen for 11 regimens in the immediate (first 6-months) and extended (all follow-up on initial regimen) periods using linear mixed models adjusted for time on regimen, interaction between time and regimen, age, sex, race/ethnicity, hepatitis B/C coinfection, nadir CD4, smoking, diabetes, antipsychotic medication, and site. We included more recently approved regimens (e.g. with tenofovir alafenamide fumarate (TAF)) only in the immediate period analyses to ensure comparable follow-up time.

RESULTS: Mean follow-up was 1.9 years on initial ART regimen. In comparison to efavirenz/tenofovir disoproxil fumarate (TDF)/emtricitabine (FTC), initiating bictegravir/TAF/FTC (3.9 kg (95% CI:2.2-5.5)) and dolutegravir/TAF/FTC (4.4 kg (95% CI: 2.1-6.6)) were associated with the greatest weight gain in the immediate period, followed by darunavir/TDF/FTC (3.7 kg (95% CI: 2.1-5.2)) and dolutegravir/TDF/FTC (2.6 kg (95% CI: 1.3-3.9). In the extended period, compared with efavirenz/TDF/FTC, initiating darunavir/TDF/FTC was associated with a 1.0 kg (95% CI: 0.5-1.5) per 6-months greater weight gain, while dolutegravir/abacavir/FTC was associated with a 0.6 kg (95% CI: 0.3-0.9) and dolutegravir/TDF/FTC was associated with a 0.6 kg (95% CI: 0.1-1.1) per 6-months greater gain. Weight gain on dolutegravir/abacavir/FTC and darunavir/TDF/FTC was significantly greater than that for several integrase inhibitor-based regimens.

CONCLUSIONS: There is heterogeneity between regimens in weight gain following ART initiation among previously ART-naïve PLWH; we observed greater gain among PLWH taking newer INSTIs (DTG, BIC) and DRV-based regimens.

Clin Infect Dis. 2020 Nov 5;ciaa1684 doi: 10.1093/cid/ciaa1684. Online ahead of print.

COVID-19 seropositivity and asymptomatic rates in healthcare workers are associated with job function and masking

Sims MD, Maine GN, Childers KL, et al.

BACKGROUND: Although the risk of exposure to SARS-CoV-2 is higher for frontline healthcare workers, not all personnel have similar risks. Determining infection rate is difficult due to the limits on testing and the high rate of asymptomatic individuals. Detection of antibodies against SARS-CoV-2 may be useful for determining prior exposure to the virus and assessing mitigation strategies, such as isolation, masks, and other protective equipment.

METHODS: An online assessment that included demographic, clinical, and exposure information and a blood sample was collected from 20,614 participants out of ~43,000 total employees at Beaumont Health, which includes eight hospitals distributed across the Detroit metropolitan area in southeast Michigan. The presence of anti-SARS-CoV-2 IgG was determined using the EUROIMMUN assay. Results: A total of 1,818 (8.8%) participants were seropositive between April 13 and May 28, 2020. Among the seropositive individuals, 44% reported that they were asymptomatic during the month prior to blood collection. Healthcare roles such as phlebotomy, respiratory therapy, and nursing/nursing support exhibited significantly higher seropositivity. Among participants reporting direct exposure to a COVID-19 positive individual, those wearing an N95/PAPR mask had a significantly lower seropositivity rate (10.2%) compared to surgical/other masks (13.1%) or no mask (17.5%).

CONCLUSIONS: Direct contact with COVID-19 patients increased the likelihood of seropositivity among employees but study participants who wore a mask during COVID-19 exposures were less likely to be seropositive. Additionally, a large proportion of seropositive employees self-reported as asymptomatic.

Am J Cardiol. 2020 Oct 31;S0002-9149(20)31190-5. doi: 10.1016/j.amjcard.2020.10.057. Online ahead of print.

Relation of neighborhood disadvantage to heart failure symptoms and hospitalizations

Shirev TE, Hu Y, Ko Y-A, et al.

Residence in socioeconomically deprived neighborhoods may influence patient's health-related behaviors and overall health. We evaluated the association of neighborhood disadvantage on heart failure (HF) symptom burden and hospitalization rates. We characterized neighborhood deprivation in 359 HF subjects (age 56 ± 13 years, 52% black) in metropolitan Atlanta using the Area Deprivation Index (ADI). ANOVA was used to compare HF symptoms measured using the Kansas City Cardiomyopathy Questionnaire (KCCQ), and HF Self-Care Index across ADI tertiles. Zero-inflated Poisson regression was used to compare rates of recurrent HF hospitalization (HFH) across ADI tertiles. Subjects living in more deprived neighborhoods were more likely to be black, have Medicare or Medicaid insurance, and have a lower ejection fraction than those living in less deprived neighborhoods (all $P \leq 0.005$). Subjects in more deprived neighborhoods had more severe HF symptoms ($P < 0.001$), but there was no difference in HF Self-Care Index scores across ADI tertiles. Subjects living in more deprived neighborhoods had a higher odds of being hospitalized for HF than subjects in less deprived neighborhoods. Once subjects had experienced a HFH, however, the association between ADI and the risk of recurrent HFH varied by racial group. Among whites, increasing ADI was associated with a marginally decreased risk of recurrent HFH, while there was no association between ADI and recurrent HFH among blacks. In conclusion, individuals with HF living in more deprived neighborhoods have greater symptom burden and are more likely to experience a HFH than those living in less deprived neighborhoods.

Hypertension. 2020 Nov 2;HYPERTENSIONAHA12015890. doi: 10.1161/HYPERTENSIONAHA.120.15890. Online ahead of print.

Cardiovascular health and transition from controlled blood pressure to apparent treatment resistant hypertension: the Jackson heart study and the REGARDS Study

Akinyelure OP, Sakhuja S, Colvin CL, et al.

Almost 1 in 5 US adults with hypertension has apparent treatment resistant hypertension (aTRH). Identifying modifiable risk factors for incident aTRH may guide interventions to reduce the need for additional antihypertensive medication. We evaluated the association between cardiovascular health and incident aTRH among participants with hypertension and controlled blood pressure (BP) at baseline in the Jackson Heart Study (N=800) and the Reasons for Geographic and Racial Differences in Stroke study (N=2316). Body mass index, smoking, physical activity, diet, BP, cholesterol and glucose, categorized as ideal, intermediate, or poor according to the American Heart Association's Life's Simple 7 were assessed at baseline and used to define cardiovascular health. Incident aTRH was defined by uncontrolled BP, systolic BP ≥130 mm Hg or diastolic BP ≥80 mm Hg, while taking ≥3 classes of antihypertensive medication or controlled BP, systolic BP <130 mm Hg and diastolic BP <80 mm Hg, while taking ≥4 classes of antihypertensive medication at a follow-up visit. Over a median 9 years of follow-up, 605 (19.4%) participants developed aTRH. Incident aTRH

developed among 25.8%, 18.2%, and 15.7% of participants with 0 to 1, 2, and 3 to 5 ideal Life's Simple 7 components, respectively. No participants had 6 or 7 ideal Life's Simple 7 components at baseline. The multivariable adjusted hazard ratios (95% CIs) for incident aTRH associated with 2 and 3 to 5 versus 0 to 1 ideal components were 0.75 (0.61-0.92) and 0.67 (0.54-0.82), respectively. These findings suggest optimizing cardiovascular health may reduce the pill burden and high cardiovascular risk associated with aTRH among individuals with hypertension.

Am J Hypertens. 2020 Oct 29;hpaa173. doi: 10.1093/ajh/hpaa173. Online ahead of print.

Characteristics of US adults who would be recommended for lifestyle modification without antihypertensive medication to manage blood pressure

Jackson SL, Park S, Loustalot F, et al.

BACKGROUND: The 2017 American College of Cardiology/American Heart Association Guideline for blood pressure (BP) management newly classifies millions of Americans with elevated blood pressure or stage 1 hypertension for recommended lifestyle modification alone (without pharmacotherapy). This study characterized these adults, including their CVD risk factors, barriers to lifestyle modification, and healthcare access.

METHODS: This cross-sectional study examined nationally representative National Health and Nutrition Examination Survey data, 2013-2016, on 10,205 US adults aged ≥18, among whom 2,081 had elevated blood pressure or stage 1 hypertension and met 2017 ACC/AHA BP Guideline criteria for lifestyle modification alone. Results: An estimated 22% of US adults (52 million) would be recommended for lifestyle modification alone. Among these, 58% were men, 43% had obesity, 52% had low quality diet, 95% consumed excess sodium, 43% were physically inactive, and 8% consumed excess alcohol. Many reported attempting lifestyle changes (range: 39%-60%). Those who reported receiving health professional advice to lose weight (adjusted prevalence ratio 1.21, 95% confidence interval 1.06-1.38), reduce sodium intake (2.33, 2.00-2.72), or exercise more (1.60, 1.32-1.95) were significantly more likely to report attempting changes. However, potential barriers to lifestyle modification included 28% of adults reporting disability, asthma, or arthritis. Additionally, 20% had no health insurance and 22% had no healthcare visits in the last year.

CONCLUSIONS: One fifth of US adults met 2017 ACC/AHA BP Guideline criteria for lifestyle modification alone, and many reported attempting behavior change. However, barriers exist such as insurance gaps, limited access to care, and physical impairment.

Ann Thorac Surg. 2020 Oct 27;S0003-4975(20)31756-2. doi: 10.1016/j.athoracsur.2020.09.015. Online ahead of print.

Prolonged opioid use associated with reduced survival after lung cancer resection

Chancellor WZ, Mehaffey JH, Desai RP, et al.

BACKGROUND: Lung cancer remains the leading cause of cancer death worldwide and the search for modifiable risk factors to improve survival is ongoing. There is a growing appreciation for a biological relationship between opioids and lung cancer progression. Our goal is to evaluate the association between perioperative opioid use and long-term survival after lung cancer resection.

METHODS: Retrospective analysis of 2006-2012 SEER-Medicare datasets identified all patients undergoing pulmonary resection for non-small cell lung cancer (NSCLC) stages I-III. Patients were stratified by only filling opioid prescriptions 30 days pre or postoperatively (Standard Group), filling opioid prescriptions >30 days preoperatively (Chronic Group), or filling opioid prescriptions >90 days postoperatively but not preoperatively (Prolonged Group). Kaplan-Meier survival analysis compared each group and risk-adjusted survival analysis was performed using Cox Proportional Hazards model. Results: A total of 3,273 patients were identified including 1,385 in the Standard Group (42.3%), 1,441 in the Chronic Group (44.0%), and 447 in the Prolonged Group (13.7%). Of previously opioid-naïve patients, 24.4% (447/1832) became new prolonged opioid users. Kaplan-Meier survival analysis illustrates lower overall and disease specific survival in Chronic and Prolonged opioid groups (both $p<0.0001$). After risk-adjustment, Chronic (HR 1.27, 95% CI 1.09-1.47, $p<0.01$) and Prolonged (HR 1.42, 95% CI 1.17-1.73, $p<0.01$) opioid use were independently associated with reduced long-term survival.

CONCLUSIONS: Chronic and prolonged opioid use were independently associated with reduced long-term, disease specific survival following lung cancer resection. These findings provide epidemiologic support for a biological relationship between opioid use and lung cancer progression.

Clin Gastroenterol Hepatol. 2020 Oct 27;S1542-3565(20)31496-8. doi: 10.1016/j.cgh.2020.10.038. Online ahead of print.

Efficacy and safety of extended induction with tofacitinib for the treatment of ulcerative colitis

Sandborn WJ, Peyrin-Biroulet L, Quirk D, et al.

BACKGROUND & AIMS: Tofacitinib is an oral, small molecule Janus kinase inhibitor for the treatment of ulcerative colitis (UC). The efficacy and safety of tofacitinib were demonstrated in a dose-ranging phase 2 induction trial, three phase 3 randomized, placebo-controlled

trials (OCTAVE Induction 1 and 2; and OCTAVE Sustain), and an ongoing, open-label, long-term extension trial (OCTAVE Open) in patients with moderately to severely active UC. Here, we assessed short- and long-term efficacy and safety of extended induction (16 weeks) with tofacitinib 10 mg twice daily (BID) in patients who failed to respond to initial induction (8 weeks) treatment.

METHODS: In patients who achieved a clinical response following extended induction (delayed responders), the efficacy and safety of tofacitinib were evaluated up to Month 36 of OCTAVE Open.

RESULTS: 52.2% of patients who did not achieve clinical response to 8 weeks' treatment with tofacitinib 10 mg BID in the induction studies achieved a clinical response following extended induction (delayed responders). At Month 12 of OCTAVE Open, 70.3%, 56.8%, and 44.6% of delayed responders maintained clinical response and achieved endoscopic improvement and remission, respectively. Corresponding values at Month 36 were 56.1%, 52.0%, and 44.6%. The safety profile of the subsequent 8 weeks was similar to the initial 8 weeks.

CONCLUSIONS: Overall, the majority of patients achieved a clinical response after 8 or 16 weeks' induction therapy with tofacitinib 10 mg BID. Tofacitinib 10 mg BID, administered as induction therapy for up to 16 weeks, had a comparable safety profile to 8 weeks' induction therapy. Most delayed responders at Month 36 were in remission.

Am J Gastroenterol. 2020 Oct 28. doi: 10.14309/ajg.0000000000001007. Online ahead of print.

Excess mortality after liver transplantation in young women with alcohol-associated liver disease

Lee BP, Dodge JL, Terrault NA.

INTRODUCTION: Young adults with alcohol-associated liver disease (ALD) are the fastest increasing demographic contributing to liver-related deaths; their outcomes after liver transplantation (LT) are understudied.

METHODS: Using the United Network for Organ Sharing registry, we performed sex-specific analyses because of a significant interaction between sex and the explanatory variable, age. Cox regression was used with overall post-LT death as the primary outcome, adjusted for survival characteristics and center clustering. We calculated the absolute difference in adjusted 5-year post-LT survival between patient groups. Causes of death were supplemented by manual review of free-text entries.

RESULTS: Among 42,014 LT recipients, 16,190 women (2,782 with ALD and 13,408 without ALD) and 25,824 men (9,502 with ALD and 16,322 without ALD), age of 40–50 years had the lowest risk of death. Women with ALD younger than 40 years had incrementally lower adjusted 5-year survival (95% confidence interval): 74% (63%-88%) for those aged 18–29 years, 82% (78%–87%) for those aged 30–39 years, and 90% (88%-92%) for those aged 40–49 years. Among women without ALD, men with ALD, and men without ALD, adjusted 5-year survival for ages 18–29, 30–39, and 40–49 years was similar. Among women, not men, there were significant interactions between younger age and ALD. Adjusted hazard for mortality for women with ALD vs without ALD was greater for those who aged 18-29 years (2.82 vs 1.09, P = 0.002) and 30–39 years (1.83 vs 1.09, P = 0.007 [reference age 40–49 years]). Among women with ALD, those aged 18–29 and 30–39 years had an absolute 17.7% and 9.5% excess in adjusted 5-year mortality vs similarly aged women without ALD.

DISCUSSION: Young women (age < 40) with ALD have excess mortality beyond one-year post-LT. Recurrent disease or explicit mention of alcohol was the most common identified cause of death in this demographic.

J Rheumatol. 2020 Nov 1;jrheum.200673.doi: 10.3899/jrheum.200673. Online ahead of print.

Circulating fibroblast growth factor-21 levels in rheumatoid arthritis: associations with disease characteristics, body composition, and physical functioning

Gould PW, Zemel BS, Taratuta EG, et al.

OBJECTIVE: This study evaluated associations between Fibroblast Growth Factor (FGF)-21, an adipokine associated with metabolic stress, and adverse longitudinal changes in body composition and physical functioning in patients with rheumatoid arthritis (RA).

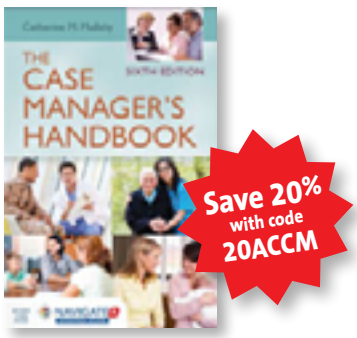
METHODS: At baseline and follow-up, RA patients, aged 18-70, completed whole-body Dual Energy Absorptiometry and peripheral quantitative CT to quantify lean mass, fat mass, and muscle density. Dynamometry assessed muscle strength at the hand and knee, and physical functioning was measured with the Health Assessment Questionnaire (HAQ) and the Short Physical Performance Battery (SPPB). FGF-21 and inflammatory cytokines were measured at baseline. Linear and logistic regression analyses assessed associations between FGF-21 levels and body composition and physical functioning over time.

RESULTS: 113 RA patients were enrolled, and 84 (74%) returned for follow-up at a median of 2.68 years. At baseline, FGF-21 was associated with age, smoking, methotrexate use, adiposity, and inflammatory cytokines: TNF-RI, YKL-40, VEGF, and resistin. The highest FGF-21 quartile was associated with worse SPPB and HAQ. Higher baseline FGF-21 levels (per 1 SD) were associated with worsening in muscle density and area z-scores [β=-0.056 (-0.12, 0.008), p=0.08; β=-0.049 (-0.10, 0.006), p=0.08] and a greater probability of a clinically meaningful worsening of HAQ [OR=2.37 (1.21, 4.64), p=0.01]. The fourth FGF-21 quartile was associated

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

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

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



THE CASE MANAGER'S HANDBOOK, 6TH EDITION

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

ORDER NOW!

BEST IN CLASS CASE MANAGEMENT ONLINE COURSE, 2.0 EDITION

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

ORDER NOW!

GOLD ENTREPRENEUR PACKAGE FOR INDEPENDENT CASE MANAGERS

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

ORDER NOW!

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

M&A
MULLAHY AND ASSOCIATES

with worsening of SPPB [β=-0.57 (-1.04, -0.091), p=0.02].

CONCLUSION: FGF-21 levels are associated with obesity and inflammatory cytokines, and with worsening in physical functioning in RA. These data support the hypothesis that FGF-21 can identify patients at risk of functional decline.

Clin Transplant. 2020 Oct 23;e14127. doi: 10.1111/ctr.14127. Online ahead of print.

Impact of donor smoking history on post heart transplant outcomes: a propensity matched analysis of ISHLT registry

Hussain Z, Yu M, Wozniak A, et al.

PURPOSE: Smoking is a major public health issue and its effect on cardiovascular outcomes is well-established. This study evaluates the impact of donor smoking on heart transplant (HT) outcomes.

METHODS: HT recipients between January 1, 2005, and December 31, 2016, with known donor smoking status were queried from the International Society of Heart and Lung Transplantation (ISHLT) registry. The primary outcome was all-cause mortality, and secondary endpoints were graft failure, acute rejection and cardiac allograft vasculopathy. We utilized propensity-score matching to identify cohorts of recipients with and without a history of donor smoking. Hazard ratios for post-transplant outcomes for the matched sample were estimated from separate Cox proportional hazard models.

RESULTS: Of 26,390 patients in the cohort, 18.9% had history of donor smoking. Donors with history of smoking were older, predominantly male and had higher incidence of diabetes, hypertension, cocaine use, and 'high-risk' status. In propensity-matched analysis, recipients with a history of donor smoking had increased risk of death (HR 1.11, 95%CI 1.03-1.20), and higher risk of graft failure (HR 1.11, 95%CI 1.03-1.20).

Bone Marrow Transplant. 2020 Oct 31. doi: 10.1038/s41409-020-01101-z. Online ahead of print.

Prognostic factors for survival after allogeneic transplantation in acute lymphoblastic leukemia

Greil C, Engelhardt M, Ihorst G, et al.

Allogeneic stem cell transplantation (allo-SCT) offers a curative option in adult patients with acute lymphoblastic leukemia (ALL). Prognostic factors for survival after allo-SCT have not been sufficiently defined: pheno-/genotype, patients' age, conditioning regimens and remission at allo-SCT are under discussion. We analyzed the outcome of 180 consecutive adult ALL-patients undergoing allo-SCT at our center between 1995 and 2018 to identify specific prognostic factors. In our cohort 19% were older than 55 years, 28% had Philadelphia-positive B-ALL, 24% T-ALL. 54% were transplanted in first complete remission (CR1), 13% in CR2 after salvage therapy, 31% reached no remission (8% within first-line, 23% within salvage therapy). In 66% conditioning contained total body irradiation (TBI). With a median follow-up of 10 years, we observed an overall survival of 33% at 10 years, and a progression free survival of 31%. The cumulative incidence of relapse was 41% at 10 years, the cumulative incidence of non-relapse mortality 28%. Acute graft-versus-host disease (GvHD) II°-IV° occurred in 31%, moderate/severe chronic GvHD in 27%. Survival was better in patients reaching CR before allo-SCT and in those receiving TBI. No difference between patients younger/older than 55 years and between different phenotypes was observed. Survival after allo-SCT improved considerably over the last decades.

Engaging Member Talent for a Brighter Future *continued from page 8*

togetherness. With the theme of "Case Managers Can _____," the community blasted social media with photos, their completed theme statements, and activities to honor one another. The CMSA chapters received official proclamations from their respective governors, held virtual networking and educational events, and brought members together to honor the profession and each other. CMSA held a Social Media Madness contest for the chapters, with CMSA Chicago coming in first place! A Case Managers and Cocktails event allowed case managers to get together, test their knowledge of CMSA history, win prizes, and enjoy gifts from Medway Air Ambulance, the event sponsor. Members showed their CM Week spirit with CM Week–branded sweatshirts, masks, tote bags, and more. Additionally, the CMSA Foundation launched the Honor a Case Manager fundraiser to recognize case managers through notecards and video with a nominal donation. These donations are the start of a fund to support members who need assistance with membership or conference registration fees in the future. Case Managers Can… do many amazing things and this week proved just that!

The strength of the case manager community and the commitment of the CMSA membership to the profession is evident in the activities that took place over the past few months. Make the most of your membership by engaging in your professional association that is here to support you. CMSA.org CM

COVID-19 Accommodations for Health Care Worker
continued from page 9

likely can access the assistance of a certified disability management specialist (CDMS) through the occupational health clinic or human resources.

accommodations. To obtain medical certifications, individuals work closely with their doctors to discuss the demands, at-risk factors, and possible exposures of their job. The employer may also need to provide a job description to document the physical demands, environment, and other expectations or essential functions of the job as well as other details such as contact with the public and other employees.

As health care professionals continue to be essential workers on the front lines of the COVID-19 response, mitigating their risk of contagion is of vital concern. When these professionals have medical conditions that elevate their risks, additional steps and accommodations are often required for compliance with certain laws. Knowing how and when to pursue job accommodation or alternative assignments can help these professionals remain productive while reducing their risks.

Whether case managers (or other health professionals) want to pursue job accommodations for themselves or for a member of their staff, or if they simply want to educate themselves about the process, here are some key considerations:

- **Medical Certification:** Before job accommodations or other employment alternatives can be pursued, employees must obtain a medical certification from their physician to verify that they have a restriction (eg, a high-risk condition) that prevents them from working in their current environment (with or without protective gear). This medical certification is the essential documentation needed to engage in an interactive process to explore reasonable accommodations and/or suitable alternatives that would allow the case manager (or other health care professionals) to remain employed. Typically, this process also includes a disability management specialist with expertise in
- **Pursuing Accommodations:** Once medical certification is obtained, the employee and employer explore what accommodations might be suitable for mitigating risk; for example, additional protective equipment and/or increased distance from co-workers, patients, and others. Alternative employment might include reassignment to other duties, such as case review, which does not require patient contact.
- **Using Sick Leave:** If an employer cannot provide a reasonable accommodation or alternative employment, the case manager may need to use sick leave for a period of time. This would allow the individual to receive pay and retain their job. Longer-term, depending on the nature of their medical condition, the employee might qualify as having a disabling impairment, which would be determined by the disability plan or according to federal or state law. Approval of that disability would be made based on the individual merits of the disability claim filed with the insurance carrier or regulatory body.

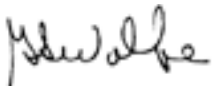
As health care professionals continue to be essential workers on the front lines of the COVID-19 response, mitigating their risk of contagion is of vital concern. When these professionals have medical conditions that elevate their risks, additional steps and accommodations are often required for compliance with certain laws. Knowing how and when to pursue job accommodation or alternative assignments can help these professionals remain productive while reducing their risks. CM

Stan Scioscia, M.Ed., CDMS, CRC, *is a Commissioner of the Commission for Case Manager Certification (CCMC), which administers the Certified Case Manager (CCM) and the Certified Disability Management Specialist (CDMS) credentials. He is also a Disability Management Services Coordinator at the University of California, Davis.*

Change in Continuing Education Credits
continued from page 2

Dashboard, you have an easy method of tracking your continuing education and processing your certification renewal.

We at *CareManagement* are committed to providing quality knowledge to improve case management practice through education!



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

ACCM: Improving Case Management Practice through Education

Early Identification of and Care for Victims of Human Trafficking *continued from page 18*

adult, health care professionals are required by law in all but three states to report injuries caused by weapons or injuries caused in violation of criminal law as well as suspected abuse or domestic violence.

Federal Antitrafficking Laws[8]

The Trafficking Victims Protection Act (TVPA) of 2000 is the first comprehensive federal law to address trafficking in persons. The law provides a three-pronged approach that includes prevention, protection, and prosecution. The TVPA was reauthorized through the Trafficking Victims Protection Reauthorization Act (TVPRA) of 2003, 2005, 2008, 2013, and 2017.

The Justice for Victims of Trafficking Act of 2015

The Justice for Victims of Trafficking Act (JVTA) of 2015 improves the US response to human trafficking. It contains a number of important amendments that strengthen services for victims. Among these amendments are changes in the criminal liability of buyers of commercial sex from victims of trafficking, the creation of a survivor-led U.S. Advisory Council on Human Trafficking, and new directives for the implementation of a national strategy for combating human trafficking.

The JVTA also requires the creation of a domestic trafficking victims' fund to support victim assistance programs, to block grants for child trafficking deterrence programs, and to provide additional training requirements for first responders, among others. Notably, the JVTA amended the Runaway and Homeless Youth Act (RHYA) by declaring that youth who are victims of severe forms of trafficking are eligible for services under the RHYA. It also amended the Child Abuse Prevention and Treatment Act (CAPTA) by adding human trafficking.

Summary

Human trafficking is believed to be one of the fastest growing and underreported illicit businesses in the world, fueled by high monetary gain. This crime involves forced labor, bonded labor, involuntary domestic servitude, forced child labor, and sex trafficking. Trafficking happens to men, women, and children in our communities and abroad.

Case managers cannot ignore victims of trafficking. Our core value is to improve a client's health, wellness, and autonomy through advocacy, communication, education, identification of services and resources, and service facilitation. Case managers are uniquely qualified to confront the ethical dilemmas that exist with trafficked victims as we recognize each person's dignity and worth.

RESOURCES

National Human Trafficking Resource Center
This national referral line can assist in finding local resources for the victim and developing a safety plan. Memorize and display the hotline information for the National Human Trafficking. 888.373.7888 or text Help to 233733

National Human Trafficking Hotline
SMS: 233733 (Text "HELP" or "INFO")
Hours: 24 hours, 7 days a week
Languages: English, Spanish and 200 more languages
Website: humantraffickinghotline.org

If You See Something, Say Something®
https://www.dhs.gov/see-something-say-something

As medical professionals, we are obliged to offer nonjudgmental support and care for the immediate needs of a trafficked victim. Collaborative care may include treatment for physical trauma, sexually transmitted infections, and pregnancy as well as resources for mental health disorders. When a victim is a minor and under 18 years of age, case managers need to be knowledgeable about the legal requirement for reporting.[9] CE

References

1. Human rights first. Human trafficking by the numbers. https://www.humanrightsfirst.org/resource/human-trafficking-numbers#:~:text=Human%20trafficking%20earns%20profits%20of,construction%2C%20manufacturing%2C%20mining%20and%20utilities. Accessed October 31, 2020.
2. Rollins R, Gribble A, Barrett SE, et al. Who is in your waiting room? Health care professionals as culturally responsive and trauma informed first responders to human trafficking. *AMA J Ethics*. 71 63:(1)19;2017. doi:10.1001/journalofethics.2017.19.1.pfor2-1701.
3. United Nations University. Our Word. A human rights approach to human trafficking, https://ourworld.unu.edu/en/a-human-rights-approach-to-human-trafficking. Accessed October 31, 2020.
4. National Institute of Justice. Overview of human trafficking and NIJ's role. https://nij.ojp.gov/topics/articles/overview-human-traffick-

continues on page 36

continued from page 26

7. hospitalized, on invasive mechanical ventilation or ECMO; and
8. death.

Overall, the odds of improvement in the ordinal scale were higher in the Veklury group at Day 15 when compared to the placebo group (odds ratio 1.54 [95% CI 1.25 to 1.91]).

Overall, 29-day mortality was 11% for the Veklury group vs 15% for the placebo group (hazard ratio 0.73 [95% CI 0.52 to 1.03]).

Study GS-US-540-5773 in Subjects with Severe COVID-19

A randomized, open-label multicenter clinical trial (Study 5773, NCT04292899) in adult subjects with confirmed SARS-CoV-2 infection, an SpO2 of ≤94% on room air, and radiological evidence of pneumonia compared 200 subjects who received Veklury for 5 days with 197 subjects who received Veklury for 10 days. Treatment with Veklury was stopped in subjects who were discharged from the hospital prior to completion of their protocol-defined duration of treatment. Subjects on mechanical ventilation at screening were excluded. All subjects received 200 mg of Veklury on Day 1 and 100 mg once daily on subsequent days via intravenous infusion, plus standard of care.

At baseline, the median age of subjects was 61 years (range, 20 to 98 years); 64% were male, 75% were White, 12% were Black, and 12% were Asian; 22% were Hispanic or Latino. More subjects in the 10-day group than the 5-day group required invasive mechanical ventilation or ECMO (5% vs 2%), or high-flow oxygen support (30% vs 25%), at baseline. Median duration of symptoms and hospitalization prior to first dose of Veklury were similar across treatment groups.

The primary endpoint was clinical status on Day 14 assessed on a 7-point ordinal scale consisting of the following categories:

1. death;
2. hospitalized, receiving invasive mechanical ventilation or ECMO;
3. hospitalized, receiving noninvasive ventilation or high-flow oxygen devices;
4. hospitalized, requiring low-flow supplemental oxygen;
5. hospitalized, not requiring supplemental oxygen but receiving ongoing medical care (related or not related to COVID-19);
6. hospitalized, requiring neither supplemental oxygen nor ongoing medical care (other than that specified in the protocol for remdesivir administration); and
7. not hospitalized.

Overall, after adjusting for between-group differences at baseline, subjects receiving a 5-day course of Veklury had similar clinical status at Day 14 as those receiving a 10-day course (odds ratio for improvement 0.75 [95% CI 0.51 to 1.12]). There were no statistically significant differences in recovery rates or mortality rates in the 5-day and 10-day groups once adjusted for between-group differences at baseline. All-cause mortality at Day 28 was 12% vs 14% in the 5- and 10-day treatment groups, respectively.

Study GS-US-540-5774 in Subjects with Moderate COVID-19

A randomized, open-label multicenter clinical trial (Study 5774, NCT04292730) of hospitalized adult subjects with confirmed SARS-CoV-2 infection, SpO2 >94%, and radiological evidence of pneumonia compared treatment with Veklury for 5 days (n=191) and treatment with Veklury for 10 days (n=193) with standard of care (n=200). Treatment with Veklury was stopped in subjects who were discharged from the hospital prior to completion of their protocol-defined duration of treatment. Subjects treated with Veklury received 200 mg on Day 1 and 100 mg once daily on subsequent days via intravenous infusion.

At baseline, the median age of subjects was 57 years (range, 12 to 95 years); 61% were male, 61% were White, 19% were Black, and 19% were Asian; 18% were Hispanic or Latino. Baseline clinical status, oxygen support status, and median duration of symptoms and hospitalization prior to first dose of Veklury were similar across treatment groups.

The primary endpoint was clinical status on Day 11 assessed on a 7-point ordinal scale consisting of the following categories:

1. death;
2. hospitalized, receiving invasive mechanical ventilation or ECMO;
3. hospitalized, receiving noninvasive ventilation or high-flow oxygen devices;
4. hospitalized, requiring low-flow supplemental oxygen;
5. hospitalized, not requiring supplemental oxygen but receiving ongoing medical care (related or not related to COVID-19);
6. hospitalized, requiring neither supplemental oxygen nor ongoing medical care (other than that specified in the protocol for remdesivir administration); and
7. not hospitalized.

Overall, the odds of improvement in the ordinal scale were higher in the 5-day Veklury group at Day 11 when compared to those receiving only standard of care (odds ratio 1.65 [95% CI 1.09 to 2.48], p=0.017). The odds of improvement in clinical status with the 10-day treatment group when compared to those receiving only standard of care were not statistically significant (odds ratio 1.31 [95% CI 0.88 to 1.95]). All-cause mortality at Day 28 was ≤2% in all treatment groups.

HOW SUPPLIED/STORAGE AND HANDLING

How Supplied

Veklury for injection: 100 mg (NDC 61958-2901-2), is supplied as a single-dose vial containing a sterile, preservative-free white to off-white to yellow lyophilized powder. It requires reconstitution and further dilution prior to administration by intravenous infusion. Discard unused portion. The container closure is not made with natural rubber latex.

Veklury injection: 100 mg/20 mL (5 mg/mL) (NDC 61958-2902-2), is supplied as a single-dose vial containing a sterile, preservative-free, clear, colorless to yellow aqueous-based solution. It requires dilution prior to administration by intravenous infusion. Discard unused portion. The container closure is not made with natural rubber latex.

Storage and Handling
Do not reuse or save reconstituted or diluted Veklury for future use. These products contain no preservative; therefore, partially used vials should be discarded.

Veklury for Injection
Store Veklury for injection, 100 mg vials below 30°C (below 86°F) until required for use.

After reconstitution, use vials immediately to prepare diluted solution. Dilute the reconstituted solution in 0.9% sodium chloride injection, USP within the same day as administration. The diluted Veklury solution in the infusion bags can be stored up to 24 hours at room temperature (20°C to 25°C [68°F to 77°F]) prior to administration or 48 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]).

Veklury Injection
Store Veklury injection vials at refrigerated temperature (2°C to 8°C [36°F to 46°F]) until required for use.

Dilute within the same day as administration. Prior to dilution, equilibrate Veklury injection to room temperature (20°C to 25°C [68°F to 77°F]). Sealed vials can be stored up to 12 hours at room temperature prior to dilution. Store Veklury injection after dilution in the infusion bags for no more than 24 hours at room temperature (20°C to 25°C [68°F to 77°F]) or 48 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]).

PATIENT COUNSELING INFORMATION
Advise the patient to read the FDA-approved patient labeling (Patient Information).

Hypersensitivity Reactions
Inform patients that hypersensitivity reactions have been seen in patients receiving Veklury during and after infusion. Advise patients to inform their healthcare provider if they experience any of the following: changes in heart rate; fever; shortness of breath, wheezing; swelling of the lips, face, or throat; rash; nausea; sweating; or shivering.

Increased Risk of Transaminase Elevations
Inform patients that Veklury may increase the risk of hepatic laboratory abnormalities. Advise patients to alert their healthcare provider immediately if they experience any symptoms of liver inflammation.

Drug Interactions
Inform patients that Veklury may interact with other drugs. Advise patients to report to their healthcare provider the use of any other prescription or nonprescription medication or herbal products, including chloroquine phosphate or hydroxychloroquine sulfate.

Pregnancy
Inform patients to notify their healthcare provider immediately in the event of a pregnancy.

Lactation
Inform mothers that it is not known whether Veklury can pass into their breast milk.

VERKLURY is manufactured and distributed by Gilead Sciences, Inc.

For complete prescribing information, please see Product Insert.

continued from page 34

ing-and-nijs-role#:~:text=The%20United%20Nations%20defines%20human,forced%20labor%20or%20sexual%20exploitation. Accessed October 31, 2020.

5. Polaris. Myths, facts, and statistics. https://polarisproject.org/myths-facts-and-statistics/#:~:text=In%202019%2C%20Polaris%20worked%20on,Human%20trafficking%20is%20notoriously%20underreported. Accessed October 31, 2020.
6. United Nations. Office on drugs and crime. UNODC on trafficking in person and smuggling of migrants.https://www.unodc.org/unodc/human-trafficking/. Accessed October 31, 2020.
7. CCMC. Code of Professional Conduct for Case Managers with Standards, Rules, Procedures, and Penalties. http://amedcoedu.com/eSystems/CCMC/CECenter/CCMC_CoC.pdf. Accessed October 31, 2020.
8. U.S. Department of State. International and domestic law. https://www.state.gov/international-and-domestic-law/. Accessed October 31, 2020.
9. youth. gov. How do I report a suspected incidence of human trafficking. https://youth.gov/youth-topics/how-do-i-report-suspected-incidence-human-trafficking. Accessed October 31, 2020.

Resilience During Difficult Times
continued from page 11

management company can plan well and have strong reasons to move in new directions.

Tenacity is a skill that is persistent and allows one to bounce back, to be realistic, and to be optimistic. This means organizations must know what they do, how well they do it, and where they need to improve or bounce back. It involves communication, collaboration, and problem solving to deal with issues and make changes for improvement. In difficult times this is critical since the tendency is to blame rather than to solve problems.

Health includes the components of nutrition, sleep, exercise, proper medication, and psychological support. This is important for both the individuals you serve as well as for yourself. These issues are critical during the pandemic. Social isolation, fear, and poor habits all impact health. Your individual plans and discharge plans need to include these issues. You also need to care for yourself to be at your best.

The final domain is **collaboration.** For success we must develop supportive networks and relationships, understand and know the social determinants of health that impact those you serve, and manage perceptions during these difficult times. The ability to work within the social determinants of health and have partners in the community support those you serve is critical for success. This may mean the development of new relationships and partners, removing bias or filters about groups and individuals, and recognizing that without this collaboration your jobs are much more difficult and the sustainability of your work will be impacted.

As case managers you are providers that intersect with life and health. Build your resilience capability.

Build provider person served relationships.

Foster provider person served relationships.

Strengthen provider person served relationships.

Maintain provider person served relationships. CM

Making the Most of Virtual Training
continued from page 6

For example, even in virtual sessions, people still use their critical thinking skills in virtual sessions. In addition, virtual training for clinicians also requires them to use their clinical judgment. These skills are not replaced by technology; rather, technology becomes a tool for deploying these skills.

There is another potential added benefit. As health care increasingly embraces telehealth, becoming more comfortable with technology can help case managers adapt to this trend. The experience of interacting with others via a livestreaming training session can help case managers build their skills and experience by communicating virtually.

The bottom line: don't be afraid of virtual training but instead embrace it. Be patient, be open. The benefits are not only in the material you'll be learning but also in becoming more comfortable in the virtual world. CM

Salute to Military and Veterans Affairs Case Managers
continued from page 10

health care systems, and the CMSA Standards of Practice are used. Case managers have certifications in nursing and social work specialties as well as case management; case management certifications are from the Commission for Case Management Certification (CCMC), Academy of Certified Case Managers (ACM), American Nurses Credentialing Center (ANCC), and others.

There are case management niche and specialized programs within the DOD and VA that are designed to safely and efficiently transition care between both health care systems. TRICARE's two major companies, Health Net Federal Services and Humana Military Health Care, also have case management programs throughout the United States. The DOD and VA case managers practice in the same manner as civilian case managers including but not limited to documentation, caseload, cost-benefit analyses, use of case management process, CCMC ethical standards, transitions of care, resource utilization, and multidisciplinary care coordination.

I had the awesome opportunity to influence policy within the DOD. As a policy analyst and Medical Management Director as well as Commander and Assistant to the Air Force Surgeon General, my leadership teams contributed to case management coding requirements, respite care legislation, designation of federal and recovery care coordinators, national case management contracts, wounded warrior programs, curriculum and training publications, and the Military/Veterans/DOD preconference at CMSA annual conferences. Many advancements have been made in the DOD and VA case management programs, and there are many stories to be told as both systems combat the effects of COVID-19. I salute DOD and VA case managers everywhere. Share your powerful stories every chance you get! CM

REFER A COLLEAGUE TO ACCM

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

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

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

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

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

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

Q: Are CE exams available online?

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

Q: Where can I get my membership certificate?

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

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

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

Q: Do CE programs expire?

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

Q: Is your Website secure for dues payment?

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

application on next page

join/renew ACCM online at www.academyCCM.org

HOW TO CONTACT US

CareManagement

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

Editor-in-Chief/Executive Vice President: Gary S. Wolfe, RN, CCM, 541-505-6380
email: gwolfe@academyccm.org

Executive Editor: Catherine M. Mullahy, RN, BS, CRRN, CCM, 631-673-0406
email: cmullahy@academyccm.org

Publisher/President: Howard Mason, RPH, MS, 203-454-1333, ext. 1;
e-mail: hmason@academyccm.org

Art Director: Laura D. Campbell
203-256-1515
e-mail: lcampbell@academyccm.org

Copy Editor: Esther Tazartes
e-mail: justice@dslextreme.com

Subscriptions: 203-454-1333
Website: www.academyCCM.org

ACCM
ACADEMY OF CERTIFIED CASE MANAGERS

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

Member Services:
203-454-1333, ext. 3
e-mail: hmason@academyccm.org

Phone: 203-454-1333; fax: 203-547-7273
Website: www.academyCCM.org

Vol. 26, No. 5, December 2020/January 2021. *CareManagement* (ISSN #1531-037X) is published electronically six times a year, February, April, June, August, October, and December, and its contents are copyrighted by Academy of Certified Case Managers, Inc., 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990;
Tel: 203-454-1333; Fax: 203-547-7273.

ACCM
ACADEMY OF CERTIFIED CASE MANAGERS

Membership Application

Do not use this application after December 31, 2020

❑ I wish to become a member.

Date _____

First Name _____ Middle Name _____ Last Name _____

Home Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ e-mail (required) _____

Certification ID #_____ *(ACCM mailings will be sent to home address)*

Practice Setting:

Which best describes your practice setting?

❑ Independent/Case Management Company
❑ Rehabilitation Facility
❑ Medical Group/IPA
❑ Hospice
❑ Consultant
❑ HMO/PPO/MCO/InsuranceCompany/TPA
❑ Hospital
❑ Home Care/Infusion
❑ Academic Institution
❑ Other: _____

JOIN ACCM TODAY!

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

❑ Check or money order enclosed made payable to: **Academy of Certified Case Managers.**
Mail check along with a copy of application to:
Academy of Certified Case Managers, 2740 SW Martin Downs Blvd. #330, Palm City, FL 34990.

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

Card # _____ Exp. Date:_____ Security Code:

Person's Name on Credit Card:_____Signature:

Credit Card Billing Address:_____

City:_____ State: _____Zip: _____

join/renew ACCM online at www.academyCCM.org

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

HEALTH CARE CASE MANAGEMENT

GET CERTIFIED. **STAY CERTIFIED.** **DEVELOP OTHERS.**

Ready to demonstrate your value?

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

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

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

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

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

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

You're on your way to great things.

GET CERTIFIED. STAY CERTIFIED. DEVELOP OTHERS.

CCMC®

Commission for Case Manager Certification | 1120 Route 73, Suite 200 | Mount Laurel, NJ 08054
ccmchq@ccmcertification.org | www.ccmcertification.org | 856-380-6836

H2R6/26/20180MBDK