CareManagement

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

Vol. 27, No. 1 February/March 2021

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FROM THE EDITOR-IN-CHIEF

Gary S. Wolfe

Embracing an Unpredictable Future: Issues and Challenges

2020 was quite a year! Although we hope that 2021 will be better, we will continue to face challenges. The COVID-19 pandemic dominated 2020, but it isn't over or under control. The consequences of the pandemic are unemployment; financial hardship; food insecurity; social distancing; virtual home schooling; coping with sickness, death, and loss; social injustice; political upheaval; and health care systems and individuals pushed to the limit and in many cases exceeding capacity. Our whole way of life has changed because of the COVID-19 pandemic. Some things will never be the same. Some new things will become the "new normal." Some things we know are better; other things are still under evaluation. As case managers we are prepared for the future because we are change agents. Anticipating, assessing, planning, and evaluating is the case management process in action.

Some of the challenges we will face in 2021 include:

- COVID-19 pandemic
- New delivery models
- Financial issues
- Racism and social justice
- Increased demands for mental health
- New and improved systems
- Knowledge

COVID-19 pandemic: The COVID-19 pandemic will continue. The number of individuals who are infected, hospitalized, and dying is overwhelming. If I listed these numbers today, they would be outdated by the time the journal was published. We must speed up access and work to achieve equitable access to COVID-19 tests, treatments, and vaccines that are safe and effective. We must all ensure that health systems are strong enough to deliver them. Getting effective tools to everyone who needs them will be key to ending this first acute phase of the pandemic and to solve the health and economic crises it has caused.

New delivery models: The pandemic has resulted in an increased use of telehealth and virtual care. Telehealth has become more consumer-oriented since it opens up a range of access of options to patients. Telehealth consulting might take the form of a video chat, a phone call, or a text. The technology was slow growing and hampered by regulations, security issues, and privacy concerns, but telehealth exploded in popularity once the pandemic made in-person visits problematic. Health organizations may find that it is more cost effective for people to receive basic care online than from in-person visits. Future HIPAA requirements will need to be addressed. Greater interoperability between vendors must be improved so that a patient does not need to navigate across different platforms for primary care, laboratory, radiology, and specialists.

Financial issues: Consumer and health care organizations have financial challenges. Insurance premiums continue to rise, and premium increases have outstripped wage growth for some time. There are concerns about insurance coverage as well as about the ability of consumers to pay for health care. Arguments over The Affordable Care Act (ACA) continue. Overturning ACA completely would change health care economics.

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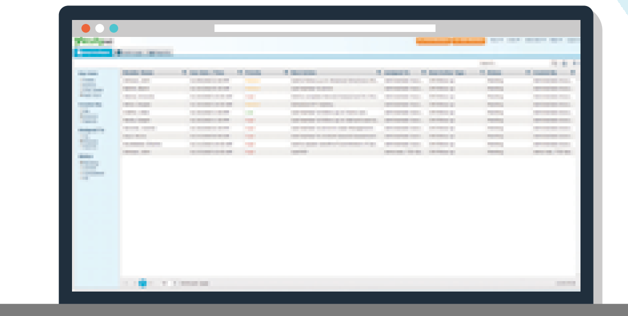

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Catherine M. Mullahy

Looking Forward

As I begin this column, we are hearing of still another—and potentially even more transmissible—mutation of the COVID-19 virus. While we are beginning a new year, the future is still unknown, which is discouraging. We wonder how long COVID-19 will continue to dominate our lives. We also wonder how long those who are on the front lines will be able to continue their incredible efforts when the end of COVID-19 is not in sight and what the short- and long-term consequences will be for their physical and mental well-being.

Each of us should take care of our patients as well as our colleagues and other members of the teams that staff our organizations. This journal continues to solicit and gratefully accepts columns from our industry partners and colleagues. These include CCMC, CDMS, CMSA, and CARF. Our Editor-in-Chief, Gary Wolfe, and I also contribute a column for each issue.

As mentioned, each of our columns have focused on a single issue: COVID-19. With this focus, each author conveyed a need to reflect on how best to move forward and committed their future efforts to succeed despite this pandemic. Each column seemed not just to be looking forward over the horizon but actively racing toward it, and not in a haphazard way but rather with optimistic determination and passion for the work that case managers are doing.

Here are a few highlights:

- From CCMC/CDMS: The article titled "Outlook 2021: Change is Here to Stay" describes a deeper appreciation for frontline workers during the continuing pandemic; a commitment to the pursuit of diversity, equity, and inclusion across health care and, more broadly, in society; and the continuing emphasis on the importance of constancy through crisis.

As we continue to collaborate with the professional organizations that have been a vital part of *CareManagement,* we are excited and proud to welcome new contributors from the Department of Veterans Affairs and the Department of Defense.

- From CARF: The article titled "Importance of Employee Recognition" urged us, during the continuing pandemic, to not only reach out to our fellow case managers with appreciation and acknowledgement of their efforts but also to learn what they have done to be successful for the population they serve, for their organizations, and for themselves.
- From CMSA: The article titled "Perspective!" embraced CMSA's past, acknowledged its accomplishments, and renewed its focus in the areas most important to its members. CMSA will partner with past leaders and the current board of directors and will make a concerted effort to mentor the future generation of case managers.

As we continue to collaborate with the professional organizations that have been a vital part of *CareManagement*, we are excited and proud to welcome new contributors from the Department of Veterans Affairs and the Department of Defense. These contributors will alternate columns that highlight the various innovative programs and case management interventions that benefit patients who have served or who are currently serving our country. As we launch this initiative, we hope to recognize work being done by these organizations and their case management staff so that their colleagues in the civilian sectors will have an enhanced understanding of the issues and challenges facing their patients, many of whom are now receiving care and services in the private sector.

Case managers are resilient and determined. They are committed to acquiring information and education to promote the best outcomes from their intervention and to communicate their contributions to those across the care continuum. *CareManagement* looks forward to being part of this and is grateful for the continuing involvement of our partners and contributors!

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.

Outlook 2021: Change Is Here to Stay

MaryBeth Kurland, CAE

Over the past year, the case management community has risen admirably to the challenge of the COVID-19 pandemic. Across multiple care settings and specialties, professional case managers continue to advocate for clients (known, in some settings, as patients) to receive the appropriate care and treatment they need, while also preventing the spread of contagion.

Overall, professionals in our community—among them, Certified Case Managers (CCMs) and Certified Disability Management Specialists (CDMSs)—have demonstrated their flexibility and adaptability, including greater use of technology such as telehealth and telephonic case management. As we look ahead, one of the valuable lessons learned from the pandemic is how technology will continue to influence case management practice in 2021 and beyond:

- **Virtual is here to stay.** Remote work and remote training became the norm during the pandemic. The success of both helped demonstrate how virtual interactions can be highly effective whether between case managers and their clients, within the care team, or among case management colleagues. Moving forward, we expect a major part of how case managers practice, interact, and pursue continuing education will be virtual. For example, the Commission for Case Manager Certification moved quickly to offer virtual training workshops. Working closely with our partner Prometric, we also adopted remote proctoring for our CCM and CDMS certification examinations. In addition, the Commission has decided to hold its 2021 New World Symposium virtually during Case Management Week, October 12–14, 2021. Postpandemic, we also expect to see a hybrid approach to learning and community-building: combining in-person experiences and virtual opportunities to learn and interact. No matter how continuing education and peer-to-peer discussions occur, workforce development remains the priority in all career stages: get certified, stay certified, and develop others.
- **Deep commitment to diversity, equity, and inclusion.** The Commission takes a proactive stance to pursue greater diversity, equity, and inclusion across health care and, more broadly, in society. We believe the overall population of professional case managers should more accurately mirror the varied demographics of the clients being served. In support of that goal, the Commission has formed a Diversity & Inclusion Subcommittee of our Executive Committee to explore how we can promote greater diversity within the Commission and in the case management and disability management specialist professions. For example, the subcommittee is examining whether unintended barriers to greater diversity exist within the professions and/or the process of certification. For many years, the Commission has worked to increase diversity, resulting in some gains in professional diversity, such as a growing number of social workers who are board-certified case managers. Other demographics, however, show the case management profession remains largely homogenous. In the CCMC's most recent role and function study, participant data reflected a case management population that is mostly white (80% of respondents) and female (94.82%). The Commission recognizes there are opportunities to grow the case management community, particularly among nurses and social workers who are part of a more diverse community but have

As we look ahead, one of the valuable lessons learned from the pandemic is how technology will continue to influence case management practice in 2021 and beyond.

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

Perspective!

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

Many definitions of the word *perspective* embrace the concept of "looking." What better time to think about "looking" toward the future and determining new and precise priorities for the year 2021. In the last half of 2020, the Case Management Society of America (CMSA) conducted rigorous organizational analyses that evolved into a new perspective for its future. Informed by members, past presidents, consultants, industry leaders in Association Management and the 2020–2022 Board of Directors, CMSA is emerging as a premier organization with renewed focus in the areas most important to our members.

The critical analyses and studied attention to new requirements for a current and post COVID-19 environment, volatile social climate, frequent public policy edicts, and a fluctuating economy fueled new perspectives on how CMSA can best support its members in the coming year and beyond. Strategy requires vision, imagination, and boldness. CMSA's members and Board of Directors have answered the call to forge new paths for the case management profession and CMSA.

How and Who delivered the data and shaped the narrative that informed CMSA's 2021 perspective? Tasks groups, representative of the multidisciplinary diversity of our membership, were organized to target specific aspects of our value proposition. Task groups were and continue to be important vehicles for relevant, cutting edge thought leadership on everything from CMSA conference planning to special projects. Similarly, committees were organized differently this year. Each member was deliberately chosen for not only their passion for CMSA but also for unique skill sets and forward-thinking perspectives on how to position CMSA for rapid and relevant response to members' and industry needs.

Perspective is revelatory, defining, and directional for any organization, but especially for CMSA as we embrace a new decade for professional case management. We are excited about the action-oriented, member-informed, and board-led approach to governance, strategy, and engagement in 2021.

CMSA has a rich history and deep professional relationships with a myriad of organizations, disciplines, and industry leaders. We were excited to invite the CMSA past presidents to serve as mentors and advisors to the pipeline of leaders, present and future. The new Legacy Leaders Council (LLC) provides CMSA with wisdom and a depth of knowledge in case management, leadership, entrepreneurship, and professionalism. CMSA is honored and grateful for their support and commitment to an organization they once led and continues to support.

While the LLC brings forth experiential wisdom, CMSA also sought the perspective of the current and future generations of case managers. We are excited to welcome the *40 under 40* group of professionals who will ensure our member organization is on the cutting edge of health care, technology, and innovation. We also welcome academia and entrepreneurs who have a new and expanded "seat at the table" to ensure CMSA policies, plans, and projects are grounded in evidence and outcomes validation when possible. All three of these groups deliver fresh perspectives to CMSA and represent the future of an organization intent on supporting members across the demographical continuum.

CMSA's perspective on interorganizational presence has also evolved. We value collaboration with entities with similar goals for advancement of the case management profession and its causes. There are many and 2021 will reveal a renewed interest in partnering with other associations, governmental entities, institutions, and entrepreneurs to advance the case management body of knowledge and commitment to improving the lives of patients/clients who are coping with complex and complicated life care issues. There is strength in numbers, and we are excited to join with others to demonstrate the awesome force of our professional voices as we advocate for case managers around the world.

Finally, CMSA's Board of Directors

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***Melanie A. Prince, MSN, BSN, NE-BC, CCM, FAAN**, is president of Case Management Society of America. Recently retired as an Air Force colonel, she is chief executive officer, Care Associates Consulting, and 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 has master's degrees in nursing case management and military strategic studies.*

The Future of Care Coordination and Case Management in the Veterans Health Administration

Melanie Rouch, LCSW, Dorothy Sanders, BSN, RN, CCM, Elizabeth Sprinkle, LCSW, Adrienne Weede, LCSW, and Lisa Perla MSN, FNP, CNRN, CRRN, CCM, PhD (candidate)

Veterans Health Administration (VHA) cares for over 9 million veterans annually and aids in the transition of care for service members from the Department of Defense to the Department of Veterans Affairs (VA) Health Care System. Care coordination and case management services are critical components to ensuring veterans can access care within the nation's largest integrated health care system. Because individuals with complex care needs are at high risk for preventable adverse health outcomes, these services have become increasingly specialized over the past two decades. In response to multiple strategic needs of the organization, this specialization has equipped the VA to serve its most vulnerable veteran populations. These include veterans who are at risk for homelessness, suicide and substance abuse, or who have sustained a traumatic brain injury. Despite these advancements, specialization also increases risks. Specifically, pockets of excellence in care coordination and case management have created gaps across clinical programs and services. Without a systemwide care coordination framework that integrates case management,- most veterans by default find themselves responsible for coordinating their own care from one setting to another. This problem is not, however, unique within the VA; the broader case management industry acknowledges the problem and professional case management societies have embraced approaches to integrate case management. "Most health systems have been disintegrated for so

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Connecting EHR Data to Evidence-Based Care Guidelines

MCG Indicia for Admission Documentation (with Synapse) helps automate clinical documentation by using real-time data from the EHR. This can help Utilization Management and Intake Clinicians reduce short-stay payer denials and focus more time on the patient.

Watch the Webinar

Headlines in Real Life

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

The COVID-19 pandemic has drawn attention to the need for healthcare professionals to use available resources and technology at a higher level of efficiency. Professional case managers know this well and have been leaders in the field of resource activation to promote optimal outcomes. From the 1135 waivers from Centers for Medicare & Medicaid Services allowing healthcare facilities to create care space wherever they can to the increased use of telehealth to continue to provide care to emergency orders in non-Compact states allowing healthcare practitioners to assist in states they may not be licensed in; healthcare is certainly looking much differently than it did just a year ago.

These events caused me to reflect on just how resilient professional case managers are and always have been in using available resources to create solutions to situations that do not always follow the "usual" healthcare trajectories. The incident below is one I often reflect on when I need inspiration to untangle a quandary. I hope it inspires you to "think outside the box".

The COVID-19 pandemic has drawn attention to the need for healthcare professionals to use available resources and technology at a higher level of efficiency. Professional case managers know this well and have been leaders in the field of resource activation to promote optimal outcomes.

Dateline: April 2018
Headline: "Synthetic Cannabinoids Tied to 4th Death in Illinois!! 95 Others Affected."

These words were splashed across the Chicago Tribune, CNN Health, and other news outlets. As a clinician, I normally pay attention to these stories as a point of professional interest. However, I didn't need the news to tell me what was going on as I had 3 of the "95 others" at one of the facilities I oversaw as Director of Case Management.

These patients all presented to the emergency department with some type of urgent bleeding issue such as bloody urine, unstoppable nosebleeds, or coughing up blood; one patient looked like he was crying tears of blood (he was). The cause was linked to synthetic cannabinoids (Spice, K2, "fake weed") being poisoned with a chemical called brodifacoum. Brodifacoum is a rat poison that kills its target by causing internal bleeding.

At the time, Illinois Department of Public Health (IDPH) officials noted that the extremely high levels of this chemical showing up in these patients made accidental contamination "unlikely" and warned that poisoning by the ingredient causes severe bleeding that can be fatal or lead to symptoms that last for months, including unexplained bruising, bleeding in the brain, and vomiting blood. These patient reports of severe bleeding led health officials to warn the public not to use any synthetic cannabinoid products at the time.

Our patients were a diverse group of young men, probably representative of all those afflicted by this health crisis:

- An over-the-road truck driver who was attending a friend's bachelor party, his friends knew he could not partake of the "real" thing due to his job. They bought some synthetic for him so he wouldn't feel left out.
- The second patient, out looking for a job, did not want to jeopardize his opportunities with the risk of testing positive on a preemployment physical.
- The third patient was in a substance use program and thought that the synthetics were a good substitute ("like that nonalcohol beer").

Once these patients had been stabilized and the major crisis resolved, we identified a huge barrier to discharge. These young men would need to be on very high dose Vitamin K for minimally

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Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, *is the Director of Inpatient Care Coordination for Cook County Health in Chicago, Illinois. She has over 15 years of experience in case management in varied roles and settings, including inpatient acute, FQHC Care Coordination, and managed care. Dr. Morley has authored articles on caseload management and care coordination strategy best practices, including health literacy.*

Importance of Employee Recognition

Christine M. MacDonell, FACRM

As I write this article at the end of 2020 and look forward to a better 2021, I am thinking about the individuals who have been working in health care during this tumultuous year. As an accreditor we had to quickly retool our product to be able to move into a digitally enabled site survey (DESS). Still, there were organizations who wanted to maintain accreditation but just were too overwhelmed with COVID-19 to even do a DESS. We invented the Continuing Accreditation during the Pandemic (CAP) Bridge process to assist those organizations. I had the privilege of doing 81 of those between June 2020 and December 2020. Currently we have 27 scheduled into 2021. These are 1-day events that cover the standards and discuss with a variety of levels of the organization how they have been achieving and using the standards in daily operations.

One of the questions I ask is what strategies have you put in place during COVID that you will continue even when the pandemic is not our main focus. Many mention tele-rehab and how that has allowed services to continue even when outpatient centers were closed. They have been able to serve more individuals who live further away from centers or who don't have transportation to the centers. Others discuss how to accomplish family/caregiver education and create a discharge plan that will be understandable and able to be implemented. Again technology is mentioned again as a key component of these activities. One that consistently is mentioned no matter the setting is communication, communication, communication. Ensuring that everyone has the information and that there are multiple channels, for example, face to face, town halls, emails, newsletters, testing, rounding, communication centers, and communication boards, to receive information.

An article in *Forbes* noted that "Recognition is the number one thing managers can give to their employees to inspire them for producing great work. Not even pay hikes, promotions, or autonomy come closer to recognition when it comes to motivating employees."

All of us in health care read or have experienced the outpouring of support for front line workers but as the surge upon surge occurs you hear more frontline workers saying "wait, we are overwhelmed, you are not following the simplest of requirements, we are tired, we have no beds." We can't forget to recognize these health care heroes.

Employee recognition is the practice of acknowledging an individual or team for their hard work and achievement that align with the company's goals. During this pandemic we have to consistently and often recognize the work that is being done. An article in *Forbes* noted that "Recognition is the number one thing managers can give to their employees to inspire them for producing great work. Not even pay hikes, promotions, or autonomy come closer to recognition when it comes to motivating employees." In an article in Socialcast, 69% of workers agreed that they would work harder if their efforts were better appreciated.

In these difficult times it is critical that we recognize the importance of maintaining an engaged workforce even when those individuals are facing their own challenges at home and in their communities. Working in health care has always been challenging, but in the pandemic it has become dangerous. The dedication, compassion, empathy, and desire to be there for individuals who are impacted by COVID-19 must be recognized, and robust recognition practices cannot be forgotten during this difficult time. Please reach out to your fellow case managers and recognize the work they have done and are doing during this difficult time. Reach out and learn what they have done to be a success for the individuals they serve, for their organizations, and for themselves.

We all can learn and grow from this experience. I will leave you with "Remain positive, test negative"! Here is to a better 2021 with recognition of all our health care heroes. CM

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.*

Fraud Enforcers Working More Closely Together

Elizabeth Hogue, Esq.

On December 4, 2020, the U.S. Department of Health & Human Services (HHS) announced the formation of a False Claims Act (FCA) Working Group. The purpose of the Group is to enhance its partnership with the U.S. Department of Justice (DOJ) and the HHS Office of Inspector General (OIG) to combat fraud and abuse. This means that the feds are now working together even more closely. Watch out!

The Group is based, in part, on the premise that fraud on the federal government is not a victimless crime. Every dollar taken by fraudsters is a dollar that cannot be used by the American people to address important health issues, including COVID-19.

The monies available to fraudsters from the federal government are substantial. In 2020, HHS regulated over a third of the US economy, and provided over $1.5 trillion in grants and other payments to public and private recipients. HHS also paid over $170 billion in 2020 to thousands of contractors. Not to mention the unprecedented levels of support for private individuals and organizations to combat COVID-19.

The False Claims Act was originally enacted by Congress in response to fraud by defense contractors during the Civil War. The FCA applies to all providers who receive federal or state healthcare funds, including, but not limited to, the Medicare, Medicaid, Medicaid waiver, VA, and TriCare Programs.

The False Claims Act has become a powerful tool the government uses to pursue those who defraud government payment programs. Those who knowingly submit false claims to the government may be liable for treble damages plus penalties that may range from approximately $11,000 to $23,000 per false claim. The government may pursue such actions on its own, or private citizens may file FCA suits on behalf of the government in qui tam or whistleblower actions and receive a portion of any recovery.

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The HHS Office of the General Counsel (OGC) created the False Claims Act Working Group to strengthen the working relationship with DOJ and the OIG. The Group includes former DOJ and healthcare fraud prosecutors, former private counsel for healthcare and life sciences companies, and HHS attorneys with extensive experience with vulnerable payment programs. The Group will identify potential FCA violations and refer them to DOJ and OIG for enforcement action. The Working Group will also help DOJ and OIG in FCA enforcement actions by providing HHS' information about the intricate legal frameworks of the agency's numerous funding programs.

HHS recognizes that close coordination with DOJ and OIG has always been needed, but the importance has been underscored by administration of significant supplemental funds to combat the pandemic. While the vast majority of private individuals and organizations have used funds in good faith to combat the pandemic, bad actors continue to operate.

- The Group will take a number of steps to enhance prevention of fraud and abuse, including:
- Provide enhanced and targeted training to HHS programs most vulnerable to fraud and abuse, which will allow OGC attorneys and HHS program operators to better detect and refer potential false claims to DOJ and OIG
- Provide a focal point within HHS for consultation about legal requirements and recommendations about alleged violations
- Serve as the conduit to over six

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

Improving Hemoglobin A1C Using Diabetes Self-Management Education in a Free Clinic

Caroline Henderson Dowd, DNP, FNP-C

Introduction

In 2015, diabetes was the seventh leading cause of death in the United States.[1] Diabetes can result in numerous complications, including diabetic retinopathy, kidney failure, heart disease, diabetic neuropathy, and diabetic foot disease.[2] Additionally, diabetes cost $327 billion in the United States in 2017 related to medical spending and decreased work productivity.[1] The American Diabetes Association (ADA) Standards of Care for 2019 recommend a goal A1C of <7.0% for adults with diabetes.[3] Many factors influence the level of glycemic control among patients with diabetes, including socioeconomic status, access to and quality of care, provider education about the disease, effective self-management, diet and exercise, and coexisting medical conditions.[4] Diabetes disproportionately affects those who are minorities and underserved, such as populations that are low-income, qualify for Medicaid, or have cultural and/or language barriers to accessing care. Minorities are also more likely to have microvascular complications associated with diabetes and amputation of lower limbs, which can further disability.[5]

The ADA recommends A1C reduction through lifestyle modifications, including dietary changes, exercise, and weight loss for better health outcomes. The guidelines also support the use of diabetes self-management education (DSME) to address lifestyle modifications and improve glucose control.[3] Per the National Standards for Diabetes Self-Management Education and Support, DSME is defined as a joint and continuous effort to assist in developing knowledge and skills needed to effectively manage one's diabetes.[6] Components of DSME include pathophysiology of diabetes and types of treatment, healthy eating, physical activity, use of medication, monitoring one's own health data, preventing and treating complications, healthy coping skills, and solving problems.[7]

At the free clinic project site in the southeastern United States, the average A1C among patients with uncontrolled diabetes (A1C ≥7.0%) is 9.5%, based on data from charts of all patients with an International Classification of Diseases, 10th Revision (ICD-10) code associated with type 2 diabetes mellitus (T2DM); there were about 500 patients at the time of project inception. A random chart review of patients diagnosed with T2DM found that providers at the clinic routinely prescribe blood glucose–lowering medications per ADA guidelines. Upon discussions with patients and providers, it became apparent that poor adherence to lifestyle recommendations per the ADA was a major contributor to elevated A1C levels among patients with T2DM at the clinic.

The framework used to develop the project is the Ottawa Model of Research Use, which views research as a dynamic process and aims at putting previously created knowledge into practice. This framework is composed of three phases as follows: determining barriers to and support for translating research into practice, monitoring implementation of the intervention; and evaluating and monitoring results of implementing the intervention, including effects on patients, providers, and the practice or health system.[8]

Numerous studies have demonstrated that intense glucose control results in lower rates of progression of adverse microvascular effects, including retinopathy, neuropathy, and kidney disease as well as cardiovascular disease.[3] A literature search revealed one systematic review of randomized controlled trials (RCTs), one systematic review of RCTs and non-RCTs, an exploratory study, an observational study, and a longitudinal design study that demonstrated that when patients receive DSME they exhibit increased knowledge about how to manage their diabetes, adhere to prescribed medication and lifestyle treatment plans, and experience improved health outcomes.[9,6,10,11,12] In a quality improvement initiative for medically underserved patients, Seol and colleagues found that DSME methods that have the most positive effect on glycemic control among ethnic minorities are those done in person and in individual settings with use of a few teaching techniques such as discussion and handouts.[12] Furthermore, Seol et al. found that interventions focused on patient behaviors with an aim to further participation in their own care have been shown to enhance self-care activities such as diet, exercise, and monitoring blood glucose as well as improve measures of diabetes such as A1C, quality of life, body mass index, diabetes symptoms, and depression.[12] A meta-analysis by Ricci-Cabello et al. of 20 RCTs with over

Caroline Henderson Dowd, DNP, FNP-C, *is currently working as a registered nurse for COVID-19 relief at Vanderbilt University Medical Center. She received her DNP as a family nurse practitioner from the Medical University of South Carolina.*

In 2015, diabetes was the seventh leading cause of death in the United States. Diabetes can result in numerous complications, including diabetic retinopathy, kidney failure, heart disease, diabetic neuropathy, and diabetic foot disease.

3,000 patients identified as ethnic minorities found that DSME methods among this population resulted in an average 0.31% reduction in A1C.[13]

The purpose of this quality improvement project was to reduce A1C levels among patients ≥18 years with a diagnosis of T2DM at the free clinic site.

Methods

At a free medical clinic in the southeastern United States, there are over 500 patients diagnosed with T2DM who are seen by three endocrinologists on Thursdays. The patient population for this project is uninsured 18 to 65-year-olds with an ICD-10 diagnosis of T2DM. Codes for diagnosis of diabetes include all ICD-10 codes starting with "E11." Most patients speak Spanish as their primary language, are ethnic minorities (largely Latino and African American), and have a family income of at least 200% below the federal poverty line. The clinic has about 10,000 patient visits per year with 4,500 current active patients, defined as those who had at least one visit during 2019. There are 22 full-time employees and over 600 professional and retired volunteers, including clerks, physicians, pharmacists, nurse practitioners, physician assistants, nurses, and translators. The clinic serves as a precepting site for students studying to be nurse practitioners, physician assistants, pharmacists, and physicians, with a typical maximum of 3–4 graduate-level students per day.

Four main interventions were implemented: a provider educational in-service was provided, twice-monthly group DSME sessions were provided for patients diagnosed with T2DM, DSME was provided during individual visits for patients diagnosed with T2DM, and patients who had not previously met with the certified diabetes educator (CDE) were referred for an appointment. First, diabetes providers received an educational in-service covering the significance of the clinic problem, the importance of providing comprehensive DSME to patients with T2DM, and how to implement the interventions.

Next, group DSME sessions for patients diagnosed with T2DM were conducted two Thursdays per month during the clinic day for the 6-month duration of the project and presented by a candidate for a doctorate in family nursing practice (DNP). All sessions lasted for approximately 30 minutes. Each session included a PowerPoint presentation based on the American Association of Diabetes Educators Seven (AADE-7) Self-Care Behaviors, including healthy eating, being active, use of medication, monitoring one's health data, preventing and treating complications, healthy coping skills, and problem solving,[14] recited in both English and Spanish. Patients were provided copies of the oral presentation in their primary language. Patients were also provided additional handouts covering portion sizes and appropriate foods; activity suggestions; how to inspect and the importance of inspecting one's feet; coping with emotional stressors; and tracking documents for diet, activity, and blood glucose monitoring. All handouts were standardized ADA patient education materials. Attendance at group sessions was recorded on paper, patient names were assigned a number, and numbers were transferred to a spreadsheet for data tracking.

Patients diagnosed with T2DM were also educated on DSME behaviors in at least one routine visit during the project. The aim of individual DSME was for the provider to briefly review the components of DSME as defined above (healthy eating, being active, use of medication, monitoring one's own health data, preventing and treating complications, healthy coping skills, and problem solving) and to provide the same handouts as those for the group sessions. Providers were to document if DSME was provided in the paper chart on the diabetes tracking flowsheet.

Finally, all patients diagnosed with T2DM at the clinic were referred to the CDE for at least one visit if the patient was newly diagnosed or was previously diagnosed but had not met with the CDE yet. The referrals were documented in the diabetes tracking flowsheet in the patient chart. The CDE and patient set individual patient goals regarding nutrition, exercise/activity, and self-monitoring activities including blood glucose measurements, weight, and foot care.

Data Collection:

The project was a pre/postintervention design, with data collected from September 2019 until March 2020. The primary outcome measure and process measures were collected using patient paper charts and electronic medical records (EMRs). The primary outcome measure was the comparison of pre- to postintervention A1C data. The process measures collected include attendance at a group DSME session, receival of DSME during an individual visit, referral to the CDE if newly diagnosed or not previously referred, and attendance at a meeting with the CDE if referred during project time frame. Other outcome measures collected at

The American Diabetes Associations recommends A1C reduction through lifestyle modifications, including dietary changes, exercise, and weight loss for better health outcomes. The guidelines also support the use of diabetes self-management education to address lifestyle modifications and improve glucose control.

each visit during the project were systolic blood pressure, diastolic blood pressure, weight, and body mass index.

Data Analysis:

Data were analyzed using the paired t-test along with descriptive statistics and graphical displays. Outcome measures, including A1C, systolic and diastolic blood pressure, weight, and body mass index were compared for each patient between the first and last visits during the project. The overall percentage decrease in A1C for all patients who received an intervention was calculated to determine the success of each intervention. Results of A1C levels were compared among patients who received only group DSME, only individual visit DSME, the combination of both, and those who had an appointment with the CDE. A1C data was collected for all patients with T2DM who received an intervention; however, only data for patients with an initial A1C of ≥7.0% was analyzed and reported in this paper to assess the effects of interventions on patients with A1C levels above the ADA recommended goal of 7.0%.

Ethical Considerations:

This quality improvement project was submitted to the Medical University of South Carolina Quality Improvement (MUSC QI) Project Evaluation Self-Assessment Tool for certification as a QI program. The project met QI certification criteria and was therefore exempt from review by an institutional review board. The intervention of DSME is evidence-based as supported by the literature, and no harms to patients were identified in the literature reviewed on DSME implementation. Data collection was deidentified, entered into a spreadsheet, and stored on a password-protected server. The only individuals who accessed patient information for the project were involved providers, the CDE, and the student performing the project, all of whom were compliant with HIPAA (Health Insurance Portability and Accountability Act) regulations. This author did not have any conflicts of interest with regard to the performance of the proposed interventions.

Results:

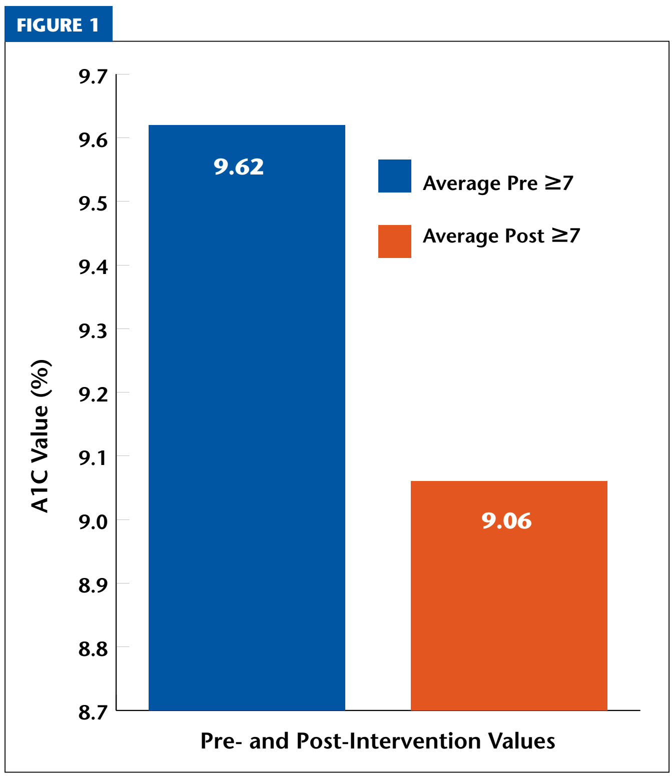
Participants

A total of 66 patients with an A1C of ≥7.0% received at least one intervention during the project time frame. The average age of the patients was 54 years old, and 59% were female. Most of the sample population (69%) was Latino, 17% were African American, and 14% were Caucasian. A total of 38 patients returned for at least one additional visit during the 6-month time frame, while 26 patients had an initial and second A1C measurement during the project.

Primary Outcome, HbA1C

When comparing patients with an initial and follow-up A1C measurement who received any intervention during the project, the average A1C decrease was 0.56%, from 9.62% to 9.06% (Figure 1). This reduction in A1C was not statistically significant based on a paired t-test, with a P value of 0.11 (alpha set at <0.05 for all data analyses). The average decrease in A1C for patients who attended a group DSME session with an initial A1C of ≥7.0% and a follow-up A1C measurement was 0.44%, from 9.91% to 9.47%. This change was not statistically significant using a paired t-test resulting in a P value of 0.208. The average decrease in A1C for patients with a starting A1C of ≥7.0% and a follow-up A1C

FIGURE 1



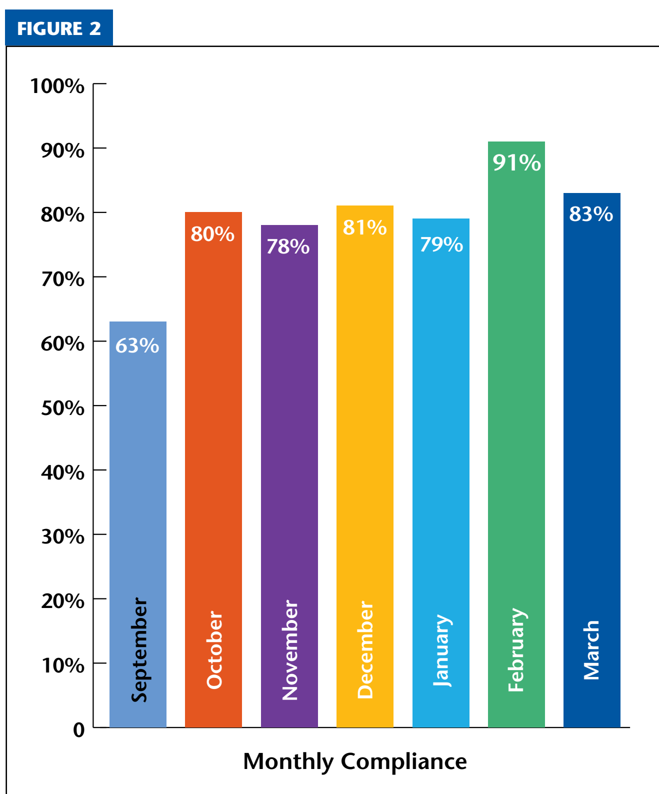
The results of this quality improvement project suggest that diabetes self-management education (DSME) has a positive effect on A1C in patients with an A1C ≥7.0%, although a longer implementation period and a combination of DSME methods may result in further improvements.

measurement who received DSME during an individual visit was 0.48%, from 9.06% to 8.58%. The average reduction in A1C for patients who received two interventions (any combination of individual or group DSME or meeting with the CDE) with an initial and follow-up A1C measurement was 1.03%, from 10.43% to 9.40%. This result was statistically significant (P = 0.02); however, these results are from only 8 patients. The average A1C reduction for patients who attended a meeting with the CDE and had a follow-up measurement was from 11.07% to 7.97%, a 3.10% decrease, but this data is based on a small sample of three patients.

Compliance

Average monthly compliance with providing either group or individual DSME at least once and referral to the CDE if not previously referred was 80.7% (92 of 114 interventions received), with monthly rates ranging from 62.5% (5 of 8 patients) during the first month to 90.1% (20 of 22 patients) in the last full month of project implementation (Figure 2).

FIGURE 2



Discussion:

Although average A1C decreased for patients who received at least one DSME intervention and had a follow-up A1C measurement, the improvement was not statistically significant. However, the reduction in average A1C levels of 0.56% generated by this project was greater than the decrease expected based on the literature findings of 0.31% from 20 RCTs involving over 3,000 patients with similar populations.[13] Issues with project implementation included providers who were noncompliant because of inadequate time during individual visits and patients who declined education. A root-cause analysis revealed the need to remind providers more consistently of the importance of DSME, to place the DSME materials in examination rooms for easy access, and to further explain the purpose of the group sessions to patients. After ensuring DSME materials were consistently placed in examination rooms, intervention compliance improved for subsequent months. Since group sessions were held in the waiting area of the clinic, the sessions were limited to 30 minutes to allow patients to attend as much of the session as possible before being called for their appointment. All patients were given paper handouts of the DSME in their primary language in case they were unable to hear the entire session and for future reference. To encourage referrals to the CDE, providers were continually reminded each week, resulting in consistent referrals as the project progressed. Strengths of the project include buy-in from the clinic director, involved providers, and the CDE; low-cost interventions; and ease of continuation at the clinic site and replication at other sites. The only requirements for the project are copies of the printed PowerPoint slides and additional ADA educational documents for each patient, a television, and a laptop or USB drive for transmitting the presentation to the television.

Limitations:

Of the 66 patients with an initial A1C ≥7.0% who received DSME, only 38 were able to return for at least one follow-up visit during the project. In addition, of the 38 patients who returned, only 26 patients had a second A1C measurement taken during the project time frame for comparison. Almost all patients whose A1C was <7.0% at the first visit during the project time frame did not have a second measurement taken during the project since their A1C was considered controlled per the ADA. Chart reviews for patients whose A1C

increased during the project revealed the following identifiable contributors: one patient missed the previous visit and ran out of diabetes medications for 3 weeks, one patient was in the process of medication titration and needed a higher dosage; and another patient traveled over the holidays, did not follow the recommended diet, and ran out of diabetes medications for 2 weeks. Factors that cannot be controlled in this clinic population include correct medication administration, access to healthy foods and safe places to exercise, and family/social support. Logistical limitations included poor access to transportation, resulting in a limited number of opportunities for DSME, and sessions only provided twice monthly because of presenter availability. The infrequency of A1C testing (every 3 months) and low rate of patient follow-up decreased the number of pre- and postintervention A1C values for comparison.

Conclusion:

The results of this QI project suggest that DSME has a positive effect on A1C in patients with an A1C ≥7.0%, although a longer implementation period and a combination of DSME methods may result in further improvements. The standardized DSME materials used in this QI project remain in the clinic for distribution to patients with T2DM. The slides used in the group sessions have been provided for streaming for use in both group and individual settings. Future recommendations for a population of ethnic minorities include providing a combination of individual and group DSME as well as meeting with a CDE, as the results from this project indicate that the greatest A1C reduction results from a combination of DSME delivery methods. The use of ADA standardized handouts with images along with a PowerPoint presentation in the patient's native language are also recommended. While the long-term effects of DSME on A1C, health care utilization and cost, and diabetes complications cannot be predicted from the results of this QI project, these relatively simple and cost-effective evidenced-based initiatives appear to lead to lowered A1C levels. CE

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Best Practices in Readmission Prevention: Summary of a Roundtable Discussion

Rebecca Perez, MSN, RN, CCM

Hospital readmissions remain one of health care's most significant challenges. Roughly 2 million individuals are readmitted to the hospital every year, costing Medicare $26 billion (CMS, 2018). Potentially $17 billion of that is attributable to avoidable readmissions (CMS, 2018). Preventing hospital admissions and readmissions has become a cost-controlling priority for hospitals and outpatient providers and payers. The Centers for Medicare & Medicaid Services (CMS) implemented the Hospital Readmission Reduction Program in 2012, which established financial penalties for hospitals with higher rates of Medicare readmissions. For outpatient providers and payers, quality metrics are related to transitions of care and activities that prevent readmission. Financial incentives are only part of the equation; however, quality and patient-centered care have become part of the focus and included as part of best practices.

The most common reasons for readmissions include advanced age, physical disabilities, the severity of illness, the presence of social determinants, and other health disparities. Readmissions also occur because of failed communication and care coordination processes such as caregiver exclusion in discharge planning and instruction, the patient's failure to grasp or fully understand the discharge plan, or necessary postdischarge services that were either not coordinated or not coordinated in a timely fashion (Stricker, 2018).

Readmission rates did not initially clearly identify or factor in social risk factors. Caring for patients experiencing low social risk factors potentiates those hospitals incurring more significant penalties and fees. An ongoing dialogue ensued shortly after CMS initiated the Hospital Readmission Reduction Program. Hospitals that served the most vulnerable patients (eg, low-income patients or patients who lacked insurance) were at risk for higher readmission rates. Some investigators who criticized evaluating social risk factors were concerned that altering performance expectations might lower care quality (Roberts, 2018). To address those disparities, the 21st Century Cures Act was passed; this Act required that CMS assess penalties based on a hospital's performance relative to other hospitals' proportion of patients eligible for Medicare and full Medicaid benefits (CMS, 2018). According to CMS, critical contributors to readmissions include poor discharge planning and transition management, no linkage to primary care, language barriers with poor access to interpreter services, low health literacy, patient education that is not culturally competent, the presence of social determinants that interfere with care access and basic needs, and co-occurring undertreated or untreated mental illness (CMS, 2018). CMS, in collaboration with other industry thought leaders, recommends the following critical components to addressing these readmissions issues in the "Guide to Reducing Disparities in Readmissions" (CMS, 2018):

1. Analyze demographics and risk data to identify the root causes of readmissions.
2. Create systems that assess risk before admission and continue to address risk before, during, and after a hospital stay.
3. Develop multidisciplinary teams with clear leadership and defined roles that communicate quickly, effectively, and respectfully with patients and other providers. These teams should be comprised of clinical and nonclinical professionals to meet the patient's specific needs.
4. Develop a response to social determinants.
5. Create systems that respond to a population's needs and address the social determinants that put them at risk for readmission.
6. Provide culturally competent communication, which is essential to patient satisfaction, adherence, and positive health outcomes. Patients must understand their condition, implications, choices, discharge instructions, when and why to keep appointments, how and why to take medications, and when to call the doctor. These communications must be available in a language and dialect that is familiar.
7. Establish partnerships and linkages to community resources to ensure continuity of care. Hospitals, outpatient

Rebecca Perez, MSN, RN, CCM, *is the author of numerous professional articles, a coauthor of CMSA's "Integrated Case Management: A Manual for Case Managers by Case Managers," developer of the Integrated Case Management Training Program, and a Master Trainer. She recently joined Parthenon Management Group as the Senior Manager of Education and Strategic Partnerships.*

Hospital readmissions remain one of health care's most significant challenges. Potentially $17 billion of that is attributable to avoidable readmission. Preventing hospital admissions and readmissions has become a cost-controlling priority for hospitals and outpatient providers and payers.

providers, and payers can support continuity of care by establishing relationships with community providers to address social determinants like transportation to appointments, food insecurity, and safe housing.

Prevention of readmissions is not just the responsibility of hospitals. High readmission rates can be attributed to adverse events like prescribing errors and misdiagnosed conditions in outpatient settings (AHRQ, 2020). A systemic effort to reduce readmissions has been lacking, which means primary care providers and payers need to take a more active role. Inadequate care coordination and ineffective transition management accounted for $25–$45 billion in wasteful spending in 2011 (LaPointe, 2018). These occur as a result of communication breakdown from hospital to postacute care or home settings. Technological and cultural barriers prevent providers from sharing information with each other and caregivers. When providers fail to communicate or coordinate care, patient confusion results. If primary care is not included in the discharge process, the situation becomes even more chaotic. Where does accountability lie? There is a need to engage primary care and specialty physicians, hospitals, and other partners in providing coordinated care. While this may seem logical and necessary, hospital processes and systems are often designed in ways that do not involve primary care practices timely or effectively. These processes and systems are potentially tied to financing regulations and incentives (Wanzhen, 2018). Many physician practices are not notified of admissions to the hospital or emergency department. Postdischarge physician visits are not scheduled within 14 days of discharge, and it is during this period that many readmissions occur (Wanzhen, 2018). Care and discharge plans are not shared; electronic health records may not communicate across health systems; payments for care coordination are additional and maybe a significant barrier (Wanzhen, 2018).

Primary care providers can reduce avoidable readmissions for newly discharged patients. Still, they need to play a more active role in the postdischarge process and better manage Ambulatory Care Sensitive Conditions. According to the publication by the Agency for Healthcare Quality and Research (AHRQ) titled "Potentially Preventable Admissions: Conceptual Framework to Rethink the Role of Primary Care," the following principles are recommended for primary care: (AHRQ, 2020)

- Become intricately involved in the postdischarge care and instructions
- Conduct postdischarge follow-up visits differently; for example, make scheduling a priority
- Use an interdisciplinary team approach to ensure high-quality care transitions that span hospital discharge to posthospital periods
- Develop a systematic approach to communication and information exchange with hospitals, payers, other physicians, postacute providers, and behavioral and social support providers
- Address the patient as a whole person using a patient-centered approach

Individual physician practices, patient-centered medical homes, and accountable care organizations (ACOs), which include groups of providers such as primary care and sometimes hospitals, can provide effective care coordination, transition management, and access to preventative services, all activities for which hospitals have little influence (Chukmaitov, 2019). Hospitals participating in ACOs are more likely to have fewer preventable hospitalizations and lower 30-day all-cause readmissions compared with hospitals that do not participate in ACOs because of infrastructure and linked communications and electronic health records (Chukmaitov, 2019). Primary care's impact on reducing admissions for Ambulatory Care Sensitive Conditions is often challenged by a patient's socioeconomic status, race, ethnicity, untreated or undertreated mental illness, and coexisting morbidities. Another challenge is the lack of inpatient and outpatient data linkage and individual-level data (Leventer-Roberts, 2020). These are needed to help prevent readmissions (Leventer-Roberts, 2020).

CMS released measures for ACOs to include patient experience, care coordination, patient safety, preventative health, and at-risk populations. For readmissions, the measures are Risk-Standardized All Condition Readmissions and Skilled Nursing Facility 30-Day all Cause Readmissions. For state Medicaid ACOs, quality measures are used to incentivize

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providers to improve patient outcomes with enhanced access and better care coordination.

Reported readmission rates are usually taken from the Medicare fee-for-service population; however, nonpregnant adult Medicaid beneficiaries experience readmission rates that are often higher than those for Medicare beneficiaries (Wanzhen, 2018). Adult Medicaid beneficiaries aged 45–64 are readmitted at a rate of 22% annually compared with Medicare beneficiaries at 16% (Wanzhen, 2018). Value-based incentives and technical assistance have been drivers to reduce readmissions, primarily for the Medicare population. But with increased Medicaid expansion due to the Affordable Care Act, practical approaches to minimize Medicaid readmissions are being sought (Wanzhen, 2018). Readmission rates do not identify or factor in social risk factors. There is an ongoing debate whether to account for social risk factors and if that alteration would hamper the quality of care delivered to an already vulnerable patient population (Roberts, 2018).

Ineffective transitions following hospital discharge and lack of engagement in follow-up care are the major contributors to readmissions for Medicaid beneficiaries (Wanzhen, 2018). Medicaid managed care organizations that invest in postdischarge engagement that includes outreach to ensure that medications are managed, that equipment and home services are coordinated, and that the patient and family or caregiver comprehend discharge instructions and when to call the doctor is understood experience a decrease in readmissions (Wanzhen, 2018). Care or case managers are primarily responsible for delivering these services because they are specially trained to coordinate care, identify serious situations before emergency intervention is required, and complete comprehensive assessments to uncover concerns that may have been missed during hospitalization at outpatient appointments. This engagement level leads to a trusted patient/case manager relationship, resulting in improved communication and patient engagement in self-care.

Supporting care across the continuum using a multidisciplinary approach improves the patient experience and reduces readmission risk.

In December 2020, the Case Management Society of America hosted a virtual roundtable discussion with industry leaders from acute care, outpatient care, and managed care. The topic was the best practices in readmission prevention. The panelists were Dr. Colleen Morley, DNP, RN, CCM, CMAC, CMCN, ACM-RN, Director of Case Management for West Suburban Hospital in Chicago, Illinois, representing acute care; Dr. Lisa Simmons-Field, DNP, RN, MSA, CCM, CPHQ, Director of Population Health and Care Management for Trinity Health representing outpatient care, specifically ACOs; and Wendy Faust, MBA, RN, CCM, CPHQ, Regional Vice President of Care Management and Disease Management Strategy and Operations for Centene Corporation representing managed care. Centene health plans are comprised of managed Medicare, Medicaid, and Marketplace.

The panel was first asked, based on their setting, what were the most common causes for readmissions. Dr. Morley shared that West Suburban Hospital needed to understand readmission reasons, so they decided there was a need to interview readmitted patients to determine the grounds. Overwhelmingly the cause was attributed to social determinants of health. Specifically, no transportation to medical appointments, low health literacy, and poor understanding of previous discharge instructions drove readmissions. These also contributed to poor medication adherence.

Dr. Simmons-Field reported similar social determinants in their population but included food insecurity and housing as contributors. She also shared a lack of understanding of the need to follow up with a physician after discharge, comorbid behavioral health conditions, and social isolation added to the challenges.

Ms. Faust reported that coordination of discharge needs and untimely arrival of needed supplies contributed to her managed Medicaid population experiencing readmission. She also said there was a significant cultural disconnect with patients' understanding of discharge instructions. Her organization views readmissions as failures, not just from a provider's perspective, but for the health care system as a whole.

The panel was next asked about the impact of quality measures on readmission prevention in light of penalties or higher reimbursement being tied to readmission rates. Some providers have editorialized that the Hospital Readmission Reduction Program has hindered quality care delivery and may contribute to some patients' mortality (McCaffrey, 2019). A 2018 study reported in *JAMA Internal Medicine* outlined

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how CMS reported savings largely attributed to penalties. Mortality was not included in those penalties, but facilities that provided a higher quality of care and prevented mortality had higher readmission rates, and it thus appeared that the Hospital Readmission Reduction Program was detrimental to quality care (McCaffrey, 2019). As you will see, the panelists found opportunities in the readmission quality measures rather than obstacles.

Dr. Morley reported that a focus on the Hospital Readmission Reduction Program decreased readmission rates at West Suburban Hospital. Her case managers are intricately involved in the discharge process and in tracking quality metrics. West Suburban Hospital focused on specific conditions and then the individuals challenged with those conditions. A more laser focus has resulted in successes rather than reducing all readmissions; identifying successes in particular areas can be carried over to other reduction projects. For the outpatient and payer settings, readmission measures focus on care transitions, prevention of adverse events resulting from poor communication, delays in care coordination, and misunderstood or poorly understood discharge instructions. According to Dr. Simmons-Field, Trinity Health includes both incentives and penalties related to readmissions in their contractual agreements. Her staff work at the top of their licensure, ensuring patients are properly assessed, that workflows are integrated, and patients are followed closely after discharge. Trinity uses portals for communication with providers so that they can analyze themselves against their peers. Trinity formed a Clinical Quality Improvement Committee to collaborate across practices to share successes and best practices for all providers' benefit.

In the payer setting, providers have historically been held accountable. Still, now that more data are available, Ms. Faust tells us that information is used to develop detailed contracts that include metrics. Specific readmission metrics are built into the contracts. The result has been that providers are willing to take more financial risk for quality. This is easier for providers that are more capable of collecting and managing data but more difficult for smaller community providers that have that type of infrastructure. She reports that managed care organizations have seen an overall decrease in readmissions with these quality-driven contracts.

The roundtable closed by asking each panelist to share their best readmission prevention practices. For Dr. Morley and West Suburban Hospital, the case managers develop comprehensive discharge plans. They schedule a follow-up appointment for the patient before leaving the hospital. The discharge planning begins well before the day of discharge with the "predischarge plan" using West Suburban Hospital's unique Health Literacy Lab to ensure patients understand their medications, equipment, and therapies. The discharge plan is reviewed in detail with the patient and family or caregiver. Patients are also encouraged to assign a power of attorney and complete an advanced directive.

At Trinity Health, case managers often use the LACE index to assess readmission risk. The LACE index identifies patients who are at risk for readmission or death within 30 days of discharge. LACE stands for length of stay, acuity, comorbidities, and emergency department visits. Scoring is applied to the four domains, and a score ≥10 indicates an increased risk of readmission. If a patient scores ≥10, the case manager will continue to follow the patient for 30–90 days postdischarge. The case manager makes sure the patient keeps all appointments, they review medications, and they monitor any potential symptoms or signs that indicate worsening health. They use telehealth tools, including video and text, to maintain contact and to connect patients to community resources like 211, Aunt Bertha, and community health workers to address social determinants of health that could pose a risk for readmission. Workflows are integrated to ensure that the discharge plan is implemented correctly and timely.

Centene case managers have begun conducting preadmission screenings and instructions for any patient with a scheduled admission. This has proven to be successful in establishing rapport and improving case management engagement. Centene recently incorporated social determinants of health into their proprietary predictive modeling to better predict potential risk. They have also begun to conduct onsite discharge planning, moving away from onsite utilization management. This has allowed better case management engagement with the patient and improved collaboration with the acute care facility for a safe and effective transition. Until the pandemic prohibited home

visits, case managers also made home visits to assess social determinants better. Pharmacists are included as part of the multidisciplinary team to conduct medication reconciliation. Secure Zoom channels have been used to continue this high touch care during the pandemic.

These three health care leaders may represent different settings, and their case managers may be focusing on different steps in the care transition process. Still, all three agreed during this discussion that one could not be successful without the other. They all agree that there is a need to continue to find ways to work collaboratively to ensure care is delivered along the continuum and that handoffs are seamless. Referring to the section in this article in which CMS provided the critical components to addressing readmissions and the recommendations for outpatient and payer strategies, these three leaders are shining examples of those components in practice.

Readmission prevention is not just the responsibility of hospitals; the responsibility lies with all phases of health care. We are in a relay, and each of us needs to carry the baton to the next leg in the race, each runner supporting the other to ensure the best outcome for all patients. CE II

***Note:** The comments by the panelists used in this article were used with the individual's permission.*

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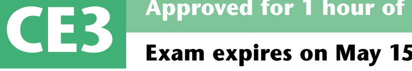
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How Practices Can Advance the Implementation of Integrated Care in the COVID-19 Era

Mary Docherty, Brigitta Spaeth-Rublee, Deborah Scharf, Erin Ferenchik, Jennifer Humensky, Matthew Goldman, Henry Chung, and Harold Alan Pincus

Toplines

- Barriers to integrated care, which combines primary health care and behavioral health care by using a team-based approach, include challenges in financing, health information technology (HIT), and workforce supply.
- The COVID-19 pandemic has magnified how advancement of HIT could increase access to integrated care.

Introduction

Behavioral health disorders are highly prevalent among U.S. adults and frequently co-occur with chronic physical health conditions.[1] The COVID-19 pandemic has created multiple psychosocial stressors and socioeconomic impacts that disproportionately affect vulnerable populations including those with comorbid behavioral and physical health conditions.[2] Traditionally, the U.S. health system has treated medical and behavioral health conditions separately, resulting in care that is often fragmented, low-quality, associated with poor outcomes, and extremely costly to deliver.[3] In Medicaid populations, for example, the cost of care is at least double for patients with co-occurring conditions. COVID-19 has both exacerbated and magnified these preexisting challenges.[4]

Integrated care combines primary health care and behavioral health care by using a team-based approach to address the needs of the whole person. Integrated care shows promise for improving health, but uptake has been challenging.[5] At present, states are tasked with leading the design and implementation of integrated care models that improve quality of care and patient outcomes at reduced cost, largely through Medicaid expansion as part of the Affordable Care Act (ACA). State designs create some structure for integrated care programs, but operational details can vary significantly across practices' administrative and community contexts.

The report *Advancing Integration of Behavioral Health*

TABLE 1 KEY COMPONENTS OF PRIMARY CARE AND BEHAVIORAL HEALTH

DOMAIN	KEY COMPONENTS
Case finding, screening, and referral to care	• Screening, initial assessment, and follow-up • Referral facilitation and tracking
Multidisciplinary care team (including patients)	• Care team • Systematic team-based caseload review and consultation • Availability for interpersonal contact between PCP and BH specialist/psychiatrist
Ongoing care management	• Coordination, communication, and longitudinal assessment
Systematic quality improvement	• Use of quality metrics for program improvement
Decision support for measurement-based, stepped care	• Evidence-based guidelines or treatment protocols • Use of pharmacotherapy • Access to evidence-based psychotherapy treatment with behavioral health specialist
Culturally adapted self-management support	• Tools utilized to promote patient activation and recovery
Information tracking and exchange among providers	• Clinical registries for tracking and coordination • Sharing of treatment information
Linkages with community/social services	• Linkages to housing, entitlement, and other social support services

into Primary Care: A Continuum-Based Framework provides a roadmap for integrating care.[6] It describes 14 components of integration organized into eight broad domains, described in Table 1.

Using the framework as a guiding structure, the study aimed to identify key strategies practices are using to successfully address operational and structural challenges to integration. As envisioned, states could then adopt and support broader implementation strategies and bring these to scale. We performed a literature review, preliminary survey, and screening interviews to identify a diverse cohort of primary care clinics that had implemented integrated care practices at an intermediate or advanced level. We then conducted semistructured interviews and site visits to describe the practice's approach, as well as barriers they ran into and the strategies they used to overcome those barriers (see "How We Conducted This Study").

Practice-specific Barriers to Integrated Care

Most practices rated themselves as having fully or nearly fully implemented four of the key components for integration: patient screenings and case findings, referral facilitation, information sharing, and using a multidisciplinary care team. Other components of integrated care such as information tracking and sharing, quality improvement through measurement-informed care, and self-management support were less developed. The capacity to connect patients to social service organizations was underdeveloped, but all practices reported that plans to improve these components were under way.

Practice interviewees described external and internal barriers to advancing integrated care (Table 2). All the internal barriers related to three issues: inadequate and unsustainable funding, technology gaps, and shortages of trained behavioral health specialists.

Practices' Strategies for Addressing Barriers to Integrated Care

Improve Integrated Care Financing and Build Sustainable Services

Our findings confirmed that adequate financing for integrated care remains challenging and impedes taking integration to scale. The majority of practices we interviewed were primarily supported through fee-for- service billing, which is

TABLE 2 BARRIERS TO INTEGRATED CARE IDENTIFIED BY PROVIDERS

EXTERNAL FACTORS	
Regulatory and policy-related barriers	• State regulations related to primary and behavioral health care providers impede integrated care delivery • Privacy laws (for example, CFR-42) limit health information sharing • Health information technology (HIT) infrastructure and data are insufficient to support regional or state Health Information Exchanges and community needs assessments • Local workforce lacks appropriately trained behavioral health specialists • Sustainable financing is limited by: – lack of reimbursement for core care processes – time-limited grants
INTERNAL FACTORS	
Barriers related to organizational structures and processes	• Establishing and maintaining integrated teams is limited by: – low buy-in from primary care practitioners – misaligned primary care and behavioral health provider cultures – misaligned workflows and appointment schedules • Building capacity to deliver team-based care is limited by: – insufficient physical space for colocation and staff expansion – fluctuations in patient flow – HIT and electronic health records that support integrated care • Sustainable financing limited by: – insufficient infrastructure to deliver care processes efficiently, including ability to bill for integrated services – administrative burden of CPT billing codes, including alignment with billing and accounting workflow

limited by a lack of billing codes to support team-based activities, care management, and non-face-to-face clinical activities.

Other challenges with fee-for-service included payer or state restrictions on same-day billing for more than one service per day, or billing a primary care and behavioral health visit on the same day. Such restrictions place limits on the ability to provide timely, interdisciplinary, team-based, and patient-centered care. Respondents also pointed to variations in payer and state policies on which licensed providers (for example, clinical social workers or licensed professional counselors) are allowed to bill for elements of integrated care as having a significant impact on practices' ability to sustain integrated services.

New billing codes. The Centers for Medicare and Medicaid Services (CMS) recently introduced two billing options to support integration: 1) time-based billing codes for the cumulative time providers spend managing patients in the context of a particular integrated care model (collaborative care model) over the course of a calendar month, and 2) general behavioral health integration billing codes. Practices' reactions to the time-based billing codes were mixed and overall were not widely used. Several providers reported that administration was complex, and their billing systems were not equipped to handle the requirements. There was also evidence of variation and confusion in how the codes could be applied to overcome profession-specific restrictions in who could bill for integrated services.

Of those providers that had successfully implemented these billing codes, the majority felt the related payments had partially but not fully compensated for all integrated care activities. Providers in smaller practices reported needing more HIT capacity and technical assistance to take advantage of these codes.

Grants. Use of federal, state, and foundation grants was extremely common. All respondents identified that grant funding had played a role in some aspect of their integrated services. Grant-related challenges included the resources needed to secure grants and the time-limited nature of the funding. Successful strategies focused on how to use grants to support sustainability. One exemplar practice created a grant development department to ensure program sustainability and growth. Another practice received additional funds from a hospital system to fund integrated care program leadership and promote ongoing growth.

Combination of funding streams. Practices reported sustaining integrated care through multiple funding streams, typically including fee-for-service payments and grants and, less frequently, value-based income streams. In one practice, this included reinvestment of productivity savings generated from contracts into additional needed services, such as resources to address social needs. The Federally Qualified Health Centers in our sample reported that prospective payment system rates —which are typically tied to overall practice costs and not CPT or time- based billing—were critical to the feasibility of delivering integrated care.

Among those few practices with value-based payment arrangements, challenges to their successful implementation included a lack of administrative infrastructure and availability of appropriate performance measures tied to integration. Another hurdle was the significant negotiating leverage needed to contract with managed care organizations (MCOs). As the Institute for Community Living's chief medical officer noted:

> Size matters here. The administrative structure required to transform . . . to value-based payment, to be big enough to contract with the managed care plans, have them give us our data and get their attention . . . we're not like the hospitals; it takes more effort on our part.

The practices that had successfully implemented value-based payment arrangements identified a close working partnership with the health plan as essential. Health plans need to be flexible and allow practices to incrementally implement these models while also supporting and assisting practices in building the necessary administrative infrastructure.

In summary, no single financial solution nor payment model appeared to satisfy practices' varying financial contexts and needs, although a range of helpful strategies were identified (Table 3). Ultimately, organizational financial acumen, resourcefulness, and a real commitment at the leadership level to delivering integrated care were deemed necessary to sustain these programs.

HIT Advances Practices Along the Integration Continuum

Implementation of HIT was described by many respondents

TABLE 3 STRATEGIES USED TO SUPPORT FINANCIAL SUSTAINABILITY

- Prioritize investment in core infrastructure (for example, health information technology)
- Subsidize integrated care through other revenue-generating activities
- Pursue broad-based funding approaches, including grants
- Provide technical support for new billing codes
- Repeal same-day and profession-specific billing requirements
- Introduce value-based payment incrementally
- Provide technical assistance to improve use of billing codes and value-based payments
- Reinvest savings into infrastructure to address social needs

as critical to delivering integrated care. They said it reduced the reliance on otherwise human- resource-intensive care processes and facilitated core clinical and administrative functions, including clinical information sharing and billing.

Preliminary and intermediate implementation of some of the key components of integration, such as patient screening, care referrals, and follow-up, could be achieved with manual processes or basic IT systems. However, more advanced activities, such as the use of clinical registries and population health analysis, required more robust technological infrastructure. Smaller practices that had made progress in this area reported that it had been a strategic priority for investment. "We must find ways to lower the IT barrier to entry in order to foster uptake of collaborative care," a physician executive with Philadelphia's Penn Primary Care told us.

Use of HIT to target specific implementation challenges. Across our sample of practice sites, HIT had been applied to advance integrated care in many different ways (Table 4). Respondents highlighted that it was helpful to view HIT as a problem-solving tool for a range of different challenges.

Embed HIT in clinical quality improvement teams. Respondents highlighted that how IT was implemented was as critical as the infrastructure itself. IT implementation needs to be seen as an iterative quality improvement process that evolves alongside integrated workflows. Marana Health Care included IT technicians and operations staff as core members of the clinical team to optimize the design, interoperability, and user-friendliness of the system.

Build partnerships with vendors and Health Information Exchanges (HIEs). Clinical information sharing in integrated care has been difficult because of strict privacy laws (that is, HIPPA CFR Part 42) and the lack of systems to share information across different providers. The practices that we interviewed identified state-level initiatives as important facilitators of information exchange.

For example, Washtenaw County Community Mental Health described how the state of Michigan's mandated use of a standardized consent form greatly accelerated the practice's efforts to build efficient systems for clinical information sharing. The practice partnered with its EHR vendor, PCE

TABLE 4 HOW TECHNOLOGY ADVANCES PRACTICES ALONG THE INTEGRATED CARE CONTINUUM

INTEGRATED CARE DOMAIN	APPLICATION OF TECHNOLOGY TO IMPROVE INTEGRATED CARE PROCESS
Case finding, screening, and referral to care	• Identify and target at-risk or priority groups • Increase efficiency of screening processes • Referral tracking • Secure, real-time messaging to increase warm handoffs
Multidisciplinary care team (including patients)	• Telepsychiatry to increase access to behavioral health specialists • Remote consultation services to support primary care practitioners • Efficient systems to conduct caseload review • Web-based staff training programs • Virtual collaborative care teams
Ongoing care management	• Built-in tracking systems to monitor patients' attendance and progress • Built-in templates supporting multidisciplinary approach
Systematic quality improvement	• Dashboards and quality reports to engage providers • Implementation of CPT billing codes • Automated billing and administrative functions • Population planning and workforce needs modelling
Decision support for measurement-based, stepped care	• Decision-support tools embedded in the electronic health record • Automated tracking of patient symptoms • Access to web-based psychotherapy and telepsychotherapy
Culturally adapted self-management support	• Remote translating services • Apps for self-management
Information tracking and exchange among providers	• Health information exchanges • Interoperable health records across settings
Linkages with community/social services	• Use of electronic platforms to link patients to services

CREATING FELLOWSHIPS TO BUILD A SKILLED AND SUSTAINABLE WORKFORCE

Fellowships address two distinct problems: They attract high-caliber candidates to a geographic area, increasing the workforce supply. Fellowships also help staff develop the appropriate skills and competencies necessary to deliver integrated care. Cherokee, Intermountain, Salud, and Community Health Network had all invested in and created specific postqualification or postdoctoral fellowships and were achieving high retention rates.

Smaller providers also were adopting this approach. Community Health Alliance in Reno, Nevada, had innovated by partnering with the University of Nevada, Reno, to create extern opportunities. They reported dual benefits of giving psychology students exposure to primary care settings and integrated care models while providing the service with needed capacity and resources to carry out several core clinical functions.

The ability to develop, fund, and benefit from fellowship schemes was influenced both by provider resourcefulness in forging arrangements with local universities and by their geographical position or proximity to academic organizations.

Systems, and Great Lakes Health Connect, one of the largest HIEs in Michigan, to build a novel e-consent system with a seamless single sign-on. This ensured that behavioral health providers could view their patients' medical records and medical providers could access their patients' behavioral health information. Grant funding and a positive working partnership with the EHR vendor, which was built on a mutual desire to innovate, were key to facilitating this relatively low-cost initiative. "The financing wasn't hard on this piece, because they saw the benefit on this," said the practice's deputy director. "We were one of the first to do this, so it's also proof of concept for them."

Build practice networks to bridge HIT gaps. Bridging solutions could be developed in the absence of comprehensive interoperable records and HIEs. Several respondents described how building networks with other practices and including patient-tracking responsibilities into clinical roles helped them improve quality of care and clinical information sharing.

Partners in Recovery in Gilbert, Arizona, for example, employed a collaborative approach to develop a network of specialist medical providers for patients with serious mental illnesses. The practice created enhanced referral processes and shared care agreements, including written agreements detailing mutual expectations around clinical communication between general medical providers and behavioral health services. The efficacy of this strategy was enhanced through quality improvement work; the practice adjusted referral processes to complement the existing provider culture. For example, the in-house primary care clinician handled referrals to external medical partners.

Building an Adequate Behavioral Health Workforce to Deliver Integrated Care

Behavioral health workforce shortages and inadequate reimbursement in the public sector often disincentivizes practitioners from pursuing employment with integrated care teams, aggravating the lack of appropriately trained clinical staff. To address these issues, the practices we interviewed focused on increasing the supply of appropriately trained clinical behavioral health staff, optimizing the existing supply, and prioritizing retention strategies of those already in the system.

Increase workforce supply. A common strategy to increase workforce supply focused on the creation of internships and fellowships.

Other approaches (in states without profession-specific reimbursement restrictions) included applying flexibility to staffing models and recruiting behavioral health professionals—psychologists, registered nurses, licensed clinical social workers, or other licensed therapists—according to local availability. Several advanced practices had developed recruitment processes to assess candidates "fit" with the organization. Flexibility, competency in diagnostic skills, and comfort with both behavioral and general medical conditions were felt to predict whether a candidate would adjust, work effectively, and remain with the organization. A small group of providers broadened their definition of "workforce" to include peer specialists and peer patient educators.

Optimize existing supply. Strategies to optimize existing workforce capacity were varied. These included intensive staff development techniques, adjustments to integrated care processes, and redefining staff roles to streamline activities with existing workflows. Stepped care approaches, often guided by treatment algorithms, were commonly used to preserve scarcer behavioral health expertise for more complex cases and to ensure that primary care clinicians and other providers with diagnostic expertise (psychologists) work to the top of their skill level. Telepsychiatry also was employed by many of our respondents both to increase patient access to behavioral health expertise and to provide supervision and support to primary care providers delivering behavioral health care (Table 5).

Two innovations addressed workforce issues with technology: Montefiore Medical Center in The Bronx, New York, was testing the impact of a virtual collaborative care model for small primary care practices with limited access to psychiatrists. In addition, Intermountain Healthcare in Salt Lake City, Utah, had prioritized workforce planning and

TABLE 5 STRATEGIES TO OPTIMIZE EXISTING INTEGRATED CARE CAPACITY

- Shorten screening tools or use two-stage screening to ensure patients with complex needs undergo more comprehensive assessments
- Prioritize at-risk or priority groups
- Redefine staff roles to preserve scarcer behavioral health resources (for example, train medical assistants to conduct screening and introduce bachelor's-level care coordinators)
- Use technology for self-screening in the waiting room
- Create a centralized assessment and referral center optimizing computerized decision support for screening, referral facilitation, and follow-up
- Use telepsychiatry for primary care consultation, learning, and delivering care
- Use medical risk stratification to allocate resource differentially according to clinical need

was working through its mental health integration service, Alluceo, to use patient population data and predictive modeling to plan and tailor staffing models directly to patient needs.

Discussion

We identified a cohort of practice sites across the United States using innovative approaches to advance integrated care. All of our respondents reported that, while this work was technically difficult and financially challenging, it was critical to their organization's mission, culture, and belief in whole-person care. They emphasized that significant policy changes are needed to enable large-scale uptake and sustainability of integrated care.

Policy Implications for States, MCOs, and Practices

States. States wishing to promote integrated care could assist by resolving regulatory barriers that hinder, rather than protect, patient safety. One example is to create integrated licenses and single standardized consent processes. States, in collaboration with the federal government, also could establish stronger incentives for implementing integrated care models and target financial and technical support to develop health information exchanges and HIT capabilities. In addition, there is a need for more robust metrics for integrated care, including valid measures of quality that share accountability across the behavioral health and primary care interface and appropriately incentivize and reward clinics for good service. To do this, states must ensure clinician, patient, and caregiver involvement in the development of measure sets.

Managed care organizations. Health plans and other MCOs can help practices develop the administrative systems for integrated care, including those needed to report quality metrics and bill for collaborative care. Providers did not identify a single solution to alleviate financing challenges, and the lack of current progress in adopting value-based payment suggests this is not an immediate panacea to funding shortfalls. Efforts might focus on MCOs working collaboratively with each other to ensure consistency in requirements placed on practices.

They also should work collaboratively with primary care practices to develop VBPs, roll out payment plans incrementally, and help practices to build the necessary systems and processes to diversify funding sources and ensure available payment options are being used to their fullest (for example, CPT billing codes).

Practice sites. Primary care practices and clinics can adopt various strategies to advance integrated care even within the current landscapes of funding constraints and workforce shortages. Prioritizing the implementation of HIT and optimizing the existing workforce can generate increased capacity to deliver integrated care more efficiently. Choosing leadership that embraces integrated care, using the whole organization's expertise to address challenges, and looking externally to build partnerships, networks, and influence with states, MCOs, and other practices also helped practices advance.

Conclusion

We identified three cross-cutting issues as critical to advancing implementation of integrated care, which should be priorities for policy targets: financing, HIT capabilities, and workforce. Even prior to the COVID-19 epidemic, the

PROMISING INNOVATIONS IN DELIVERING SELF-MANAGEMENT SUPPORT

Montefiore Medical Center was using a portfolio of patient engagement and self-management tools, including a secure online application and messaging system that allowed for longitudinal clinical monitoring, engagement, and follow-up with patients. Interactions with patients were conducted via HIPAA-compliant text messages. Patients were offered support, screening, condition monitoring, and prompts/recommendations around behavior modification, mindfulness exercises, and physical exercise.

The Institute for Community Living, New York City, and the Lowell Community Health Center, Lowell, Mass., had developed expertise in introducing peer specialists into clinical teams. Interviewees described extremely positive patient response and improvements in patient engagement. The practices were successfully using trained peers to deliver interventions in smoking cessation and exercise as well as chronic disease management support.

expansion of HIT was considered an important driver of advancing integrated behavioral health services and a tool to alleviate some workforce shortages. Our study showed that, although challenging, practices are managing to address some of these barriers and that there are ways for states and MCOs to support their efforts. Adoption of these strategies could directly help practices and inform policymakers seeking to support their efforts. The evolving impact of COVID-19 on the behavioral and physical health of our population serves to further highlight the need to accelerate adoption of these practices.

How We Conducted This Study

We performed a cross-sectional study using a series of sampling methods including literature review, surveys, and screening interviews to identify intermediate or advanced implementers across different types of primary care settings. We conducted semistructured interviews and site visits to structure our enquiry into how practices were implementing key components of the continuum- based framework, what barriers they had encountered, and the methods they had used to overcome them.

We completed interviews with clinicians and lead administrative and finance staff from 20 practices delivering integrated behavioral health and primary care. We also visited six clinical practice sites belonging to four different organizations in two states. Practice-site respondents included integrated program leads and frontline staff: primary care physicians, psychiatrists, nurse specialists, licensed clinical social workers, and psychologists. Practice-site characteristics were balanced by region and setting, provider type, insurance type, and size of population served. CE III

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Mary Docherty, B.A. (Hons), M.A., M.B.B.S. (Hons), MRCP, MRCPsych, *is a consultant liaison psychiatrist with the South London and Maudsley NHS Foundation Trust.* ***Brigitta Spaeth-Rublee, M.A.,*** *is a research associate at New York State Psychiatric Institute.* ***Deborah Scharf, Ph.D., CPsych,*** *is a clinical and health psychologist and an assistant professor of Psychology and Health Sciences at Lakehead University.* ***Erin K. Ferenchick, M.D.,*** *is a medical anthropologist and family physician.* ***Jennifer Humensky, Ph.D.,*** *is an assistant professor of Clinical Health Policy and Management (in Psychiatry) at the Columbia University Department of Psychiatry and New York State Psychiatric Institute.* ***Matthew L. Goldman, M.D., M.S.,*** *is the medical director for Comprehensive Crisis Services in the San Francisco Department of Public Health, and he is a volunteer clinical assistant professor in the UCSF Department of Psychiatry and Behavioral Sciences.* ***Harold Alan Pincus, M.D.,*** *is professor and vice chair of the Department of Psychiatry and codirector of the Irving Institute for Clinical and Translational Research at Columbia University and the New York State Psychiatric Institute.* ***Henry Chung, M.D.,*** *is senior medical director of Behavioral Health Integration Strategy at Montefiore Care Management Organization and professor of Psychiatry at the Albert Einstein College of Medicine. Editorial support was provided by* ***Maggie Van Dyke.***

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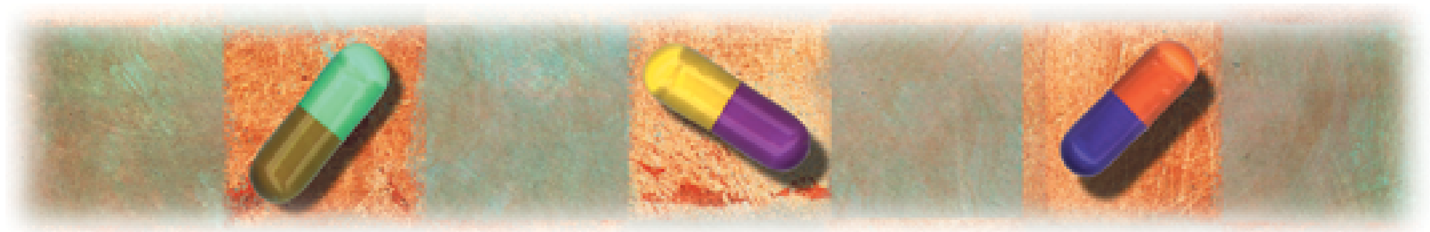

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Risk Summary

There are no data on the presence of vibegron in human milk, the effects of the drug on the breastfed infant, or the effects on milk production. When a single oral dose of radiolabeled vibegron was administered to postnatal nursing rats, radioactivity was observed in milk. When a drug is present in animal milk, it is likely that the drug will be present in human milk.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for Gemtesa and any potential adverse effects on the breastfed infant from Gemtesa or from the underlying maternal condition.

Pediatric Use
The safety and effectiveness of Gemtesa in pediatric patients have not been established.

Geriatric Use
Of 526 patients who received Gemtesa in the clinical studies for OAB with symptoms of urge urinary incontinence, urgency, and urinary frequency, 242 (46%) were 65 years of age or older, and 75 (14%) were 75 years of age or older. No overall differences in safety or effectiveness of Gemtesa have been observed between patients 65 years of age and older and younger adult patients.

Renal Impairment
No dosage adjustment for Gemtesa is recommended for patients with mild, moderate, or severe renal impairment (eGFR 15 to <90 mL/min/1.73 m^2). Gemtesa has not been studied in patients with eGFR <15 mL/min/1.73 m^2 (with or without hemodialysis) and is not recommended in these patients.

Hepatic Impairment
No dosage adjustment for Gemtesa is recommended for patients with mild to moderate hepatic impairment (Child-Pugh A and B). Gemtesa has not be studied in patients with severe hepatic impairment (Child-Pugh C) and is not recommended in this patient population.

CLINICAL STUDIES
The efficacy of Gemtesa was evaluated in a 12-week, double-blind, randomized, placebo-controlled, and active-controlled trial (Study 3003, NCT03492281) in patients with OAB (urge urinary incontinence, urgency, and urinary frequency). Patients were randomized 5:5:4 to receive either Gemtesa 75 mg, placebo, or active control orally, once daily for 12 weeks. For study entry, patients had to have symptoms of OAB for at least 3 months with an average of 8 or more micturitions per day and at least 1 urge urinary incontinence (UUI) per day, or an average of 8 or more micturitions per day and an average of at least 3 urgency episodes per day. Urge urinary incontinence was defined as leakage of urine of any amount because the patient felt an urge or need to urinate immediately. The study population included OAB medication-naïve patients as well as patients who had received prior therapy with OAB medications.

The coprimary endpoints were change from baseline in average daily number of micturitions and average daily number of UUI episodes at week 12. Additional endpoints included change from baseline in average daily number of "need to urinate immediately" (urgency) episodes and average volume voided per micturition.

A total of 1,515 patients received at least one daily dose of placebo (n=540), Gemtesa 75 mg (n=545), or an active control treatment (n=430). The majority of patients were Caucasian (78%) and female (85%) with a mean age of 60 (range 18 to 93) years.

Table 1 shows changes from baseline at week 12 for average daily number of micturitions, average daily number of UUI episodes, average daily number of "need to urinate immediately" (urgency) episodes, and average volume voided per micturition.

Figures 1 and 2 show the mean change from baseline over time in average daily number of micturitions and mean change from baseline over time in average daily number of UUI episodes, respectively.

TABLE 1 **Mean Baseline and Change from Baseline at Week 12 for Micturition Frequency, Urge Urinary Incontinence Episodes, "Need to Urinate Immediately" (Urgency) Episodes, and Volume Voided per Micturition**

Parameter	Gemtesa 75 mg	Placebo
Average Daily Number of Micturitions		
Baseline mean (n)	11.3 (526)	11.8 (520)
Change from Baseline* (n)	-1.8 (492)	-1.3 (475)
Difference from Placebo	-0.5	
95% Confidence Interval	-0.8, -0.2	
p-value	<0.001	
Average Daily Number of UUI Episodes		
Baseline mean (n)	3.4 (403)	3.5 (405)
Change from Baseline* (n)	-2.0 (383)	-1.4 (372)
Difference from Placebo	-0.6	
95% Confidence Interval	-0.9, -0.3	
p-value	<0.0001	
Average Daily Number of "Need to Urinate Immediately" (Urgency) Episodes		
Baseline mean (n)	8.1 (526)	8.1 (520)
Change from Baseline* (n)	-2.7 (492)	-2.0 (475)
Difference from Placebo	-0.7	
95% Confidence Interval	-1.1, -0.2	
p-value	0.002	
Average Volume Voided (mL) per Micturition		
Baseline mean (n)	155 (524)	148 (514)
Change from Baseline* (n)	23 (490)	2 (478)
Difference from Placebo	21	
95% Confidence Interval	14, 28	
p-value	<0.0001	

*Least squares mean adjusted for treatment, baseline, sex, geographical region, study visit, and study visit by treatment interaction term.

FIGURE 1 **MEAN (SE) CHANGE FROM BASELINE IN THE AVERAGE DAILY NUMBER OF MICTURITIONS**

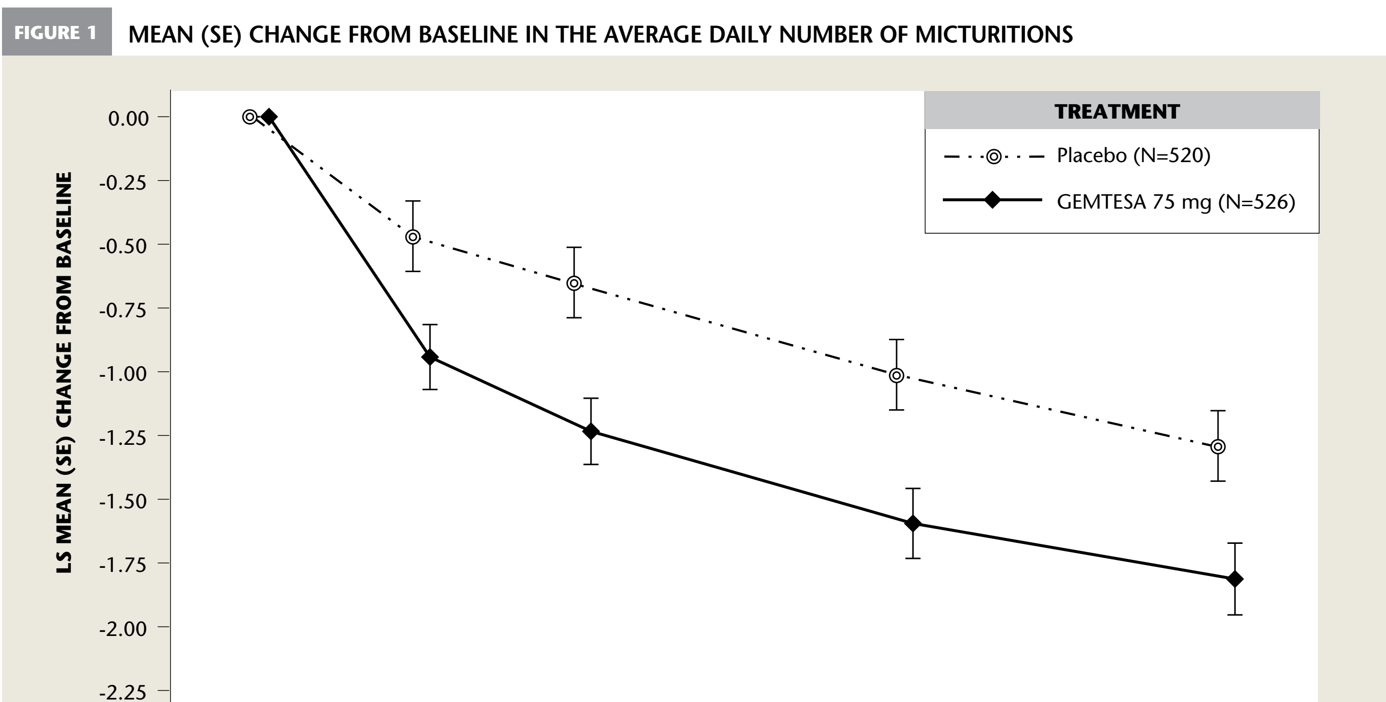
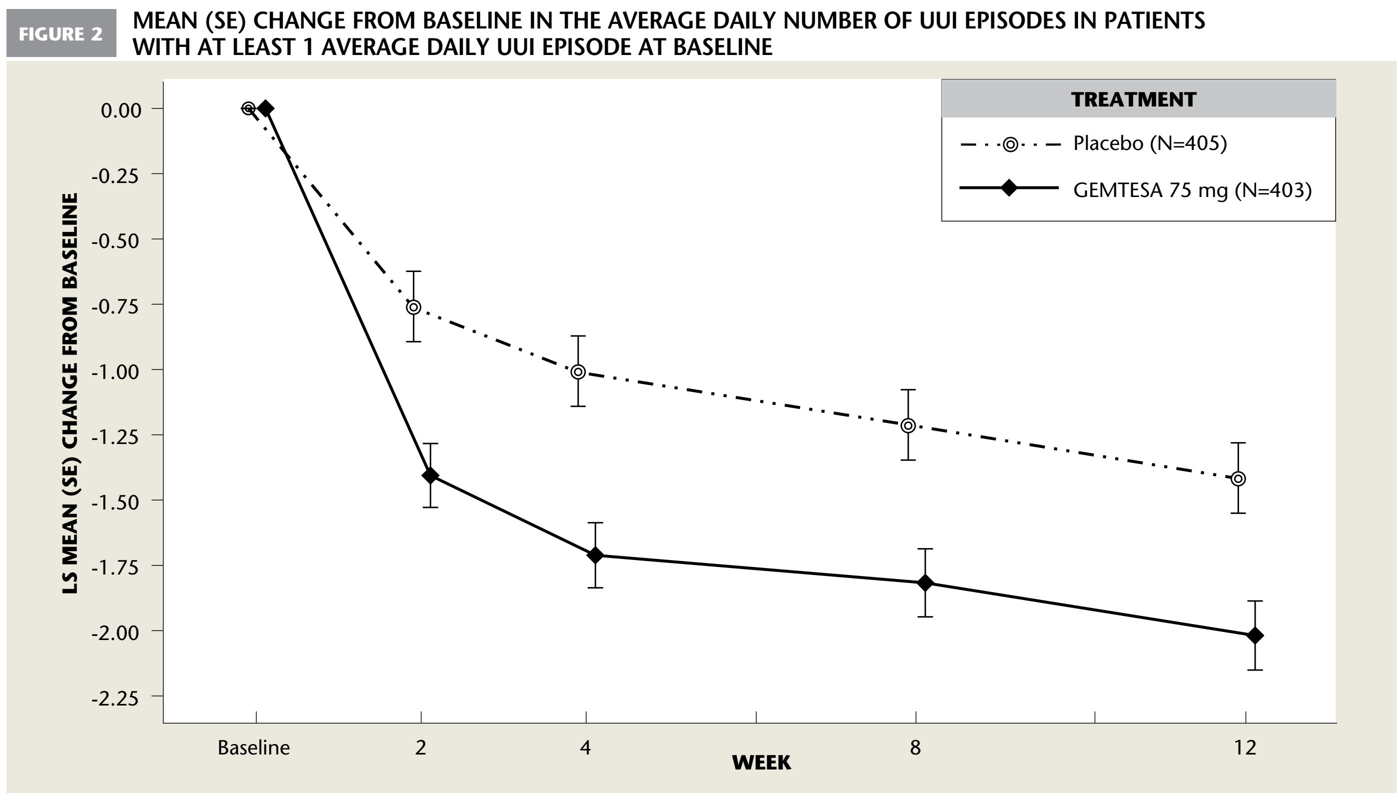


FIGURE 2 **MEAN (SE) CHANGE FROM BASELINE IN THE AVERAGE DAILY NUMBER OF UUI EPISODES IN PATIENTS WITH AT LEAST 1 AVERAGE DAILY UUI EPISODE AT BASELINE**



continued on page 40

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.

Ann Intern Med. 2020 Dec 21. doi: 10.7326/M20-6558. Online ahead of print.

College campuses and COVID-19 mitigation: clinical and economic value

Losina E, Leifer V, Millham L, et al.

BACKGROUND: Colleges in the United States are determining how to operate safely amid the coronavirus disease 2019 (COVID-19) pandemic.

OBJECTIVE: To examine the clinical outcomes, cost, and cost-effectiveness of COVID-19 mitigation strategies on college campuses.

DESIGN: The Clinical and Economic Analysis of COVID-19 interventions (CEACOV) model, a dynamic microsimulation model, was used to examine alternative mitigation strategies. The CEACOV model tracks infections accrued by students and faculty, accounting for community transmissions.

DATA SOURCES: Data from published literature were used to obtain parameters related to COVID-19 and contact-hours.

TARGET POPULATION: Undergraduate students and faculty at U.S. colleges.

TIME HORIZON: One semester (105 days).

PERSPECTIVE: Modified societal.

INTERVENTION: COVID-19 mitigation strategies, including social distancing, masks, and routine laboratory screening.

OUTCOME MEASURES: Infections among students and faculty per 5000 students and per 1000 faculty, isolation days, tests, costs, cost per infection prevented, and cost per quality-adjusted life-year (QALY).

RESULTS OF BASE-CASE ANALYSIS: Among students, mitigation strategies reduced COVID-19 cases from 3746 with no mitigation to 493 with extensive social distancing and masks, and further to 151 when laboratory testing was added among asymptomatic persons every 3 days. Among faculty, these values were 164, 28, and 25 cases, respectively. Costs ranged from about $0.4 million for minimal social distancing to about $0.9 million to $2.1 million for strategies involving laboratory testing ($10 per test), depending on testing frequency. Extensive social distancing with masks cost $170 per infection prevented ($49 200 per QALY) compared with masks alone. Adding routine laboratory testing increased cost per infection prevented to between $2010 and $17 210 (cost per QALY gained, $811 400 to $2 804 600).

RESULTS OF SENSITIVITY ANALYSIS: Results were most sensitive to test costs.

LIMITATION: Data are from multiple sources.

CONCLUSION: Extensive social distancing with a mandatory mask-wearing policy can prevent most COVID-19 cases on college campuses and is very cost-effective. Routine laboratory testing would prevent 96% of infections and require low-cost tests to be economically attractive.

Am J Med 2020 Nov;133(11):1343-1349. doi: 10.1016/j.amjmed.2020.04.025. Epub 2020 May 20.

Effect of inpatient medication-assisted therapy on against-medical-advice discharge and readmission rates

Wang SJ, Wade E, Towle J, et al.

BACKGROUND: Patients who present to the hospital for infectious complications of intravenous opioid use are at high risk for against-medical-advice discharge and readmissions. The role of medication-assisted treatment for inpatients is not clear. We aimed to assess outcomes prior to and after rollout of an inpatient buprenorphine-based opioid use disorder protocol, as well as to assess outcomes in general for medication-assisted therapy.

METHODS: This was a retrospective observational cohort study at our community hospital in New Hampshire. The medical record was searched for inpatients with a complication of intravenous opioid use. We searched for admissions 11 months prior to and after the November 2018 buprenorphine protocol rollout.

RESULTS: Rates of medication-assisted therapy usage and buprenorphine linkage increased significantly after protocol rollout. Rates of against-medical-advice discharge did not decrease after protocol rollout, nor did readmissions. However, when evaluating the entire group of patients regardless of date of presentation or protocol use, against-medical-advice discharge rates were substantially lower for patients receiving medication-assisted therapy compared with those receiving supportive care only (30.0%

vs 59.6%). Readmissions rates were lower for patients who were discharged with any form of ongoing medication-assisted therapy compared with those who were not (30-day all-cause readmissions 18.8% vs 35.1%; 30-day opioid-related readmissions 10.1% vs 29.9%; 90-day all-cause readmissions 27.3% vs 42.7%; 90-day opioid-related readmissions 15.1% vs 33.3%).

CONCLUSIONS: There is a strong association between medication-assisted therapy and reduced against-medical-advice discharge rates. Additionally, maintenance medication-assisted therapy at time of discharge is strongly associated with reduced readmissions rates.

Am Heart J. 2020 Dec 19;S0002-8703(20)30411-7. doi: 10.1016/j.ahj.2020.12.009. Online ahead of print.

Management of heart failure in cardiac amyloidosis using an ambulatory diuresis clinic

Vaishnav J, Hubbard A, Chasler JE, et al.

BACKGROUND: Recurrent congestion in cardiac amyloidosis (CA) remains a management challenge, often requiring high dose diuretics and frequent hospitalizations. Innovative outpatient strategies are needed to effectively manage HF in patients with CA. Ambulatory diuresis has not been well studied in restrictive cardiomyopathy. Therefore, we aimed to examine the outcomes of an ambulatory diuresis clinic in the management of congestion related to CA.

METHODS AND RESULTS: We retrospectively studied patients with CA seen in an outpatient HF disease management clinic for 1) safety outcomes of ambulatory intravenous (IV) diuresis and 2) health care utilization. Forty-four patients with CA were seen in the clinic a total of 203 times over 6 months. Oral diuretics were titrated at 96 (47%) visits. IV diuretics were administered at 56 (28%) visits to 17 patients. There were no episodes of severe acute kidney injury or symptomatic hypotension. There was a significant decrease in emergency department and inpatient visits and associated charges after index visit to the clinic. The proportion of days hospitalized per 1000 patient days of follow-up decreased as early as 30 days (147.3 vs 18.1/1000 patient days of follow-up, p<0.001) and persisted through 180 days (33.6 vs 22.9/1000 patient days of follow-up, p<0.001) pre- vs. post-index visit to the clinic.

CONCLUSIONS: We demonstrate the feasibility of ambulatory IV diuresis in patients with CA. Our findings also suggest that use of a HF disease management clinic may reduce acute care utilization in patients with CA. Leveraging multidisciplinary outpatient HF clinics may be an effective alternative to hospitalization in patients with HF due to CA, a population who otherwise carries a poor prognosis and contributes to high health care burden.

Clin Transplant. 2020 Dec 17;e14194. doi: 10.1111/ctr.14194. Online ahead of print.

Impact of age mismatch between donor and recipient on heart transplant mortality

Kumar A, Bonnell LN, Prikis M, et al.

The effect of donor to recipient (D-R) age mismatch in adult heart transplant population is not clearly described, and we undertook this study to determine impact of age mismatch on mortality. Heart transplant recipients from 2000-2017 were identified using the United Network of Organ Sharing database. The cohort was divided into three groups: donor age within 5 years of recipient age (Group 1), donors >5 years younger than recipient (group 2), and donors >5 years older than recipients (Group 3). We also evaluated if this finding changed by recipient age. 28,411 patients met the inclusion criteria. Compared to group 1, the adjusted hazard ratio (aHR) for mortality for group 2 was 0.91 (0.83-0.99, p value <0.039) and for group 3 was 1.36 (1.21-1.52, p value <0.001); however, when looking at recipient age as continuous variable, receiving a younger heart was protective only for recipients younger than 45 years of age, and receiving a heart transplant from an older donor was detrimental only in recipients aged 25–35.

J Infect Dis. 2020 Dec 15;jiaa760. doi: 10.1093/infdis/jiaa760. Online ahead of print.

Distinguishing amnestic mild cognitive impairment from HIV-associated neurocognitive disorders

Sundermann EE, Bondi MW, Campbell L, et al.

BACKGROUND: Memory impairment occurs in both HIV-associated neurocognitive disorders (HAND) and amnestic mild cognitive impairment (aMCI), the precursor to Alzheimer's disease (AD). Methods are needed to distinguish aMCI-associated from HAND-associated impairment in people with HIV (PWH). We developed a neuropsychological method of identifying aMCI in PWH and tested this method by relating AD neuropathology (β-amyloid, phospho-Tau) to aMCI versus HAND classification.

METHODS: Seventy-four HIV+ cases (age: 50-68) from the National NeuroAIDS Tissue Consortium had neurocognitive data within one-year of death and had data on β-amyloid and phospho-Tau pathology in frontal brain tissue. High aMCI risk was defined as impairment (<1.0 SD below normative mean) on two of four delayed recall or recognition outcomes from a verbal and non-verbal memory test (at-least one recognition impairment required). Differences in β-amyloid and phospho-Tau by aMCI and HAND classification were examined.

RESULTS: High aMCI risk classification was more common in

the HAND (69.0%) versus no HAND (37.5%) group. β-amyloid pathology was 4.75 times more likely in the high versus low aMCI risk group. Phospho-Tau pathology did not differ between aMCI groups. Neither neuropathological feature differed by HAND status.

CONCLUSIONS: amnestic mild cognitive impairment criteria that include recognition impairment may help to detect AD-like cognitive/biomarker profiles among PWH.

Thromb Res. 2020 Dec 8;198:163-170. doi: 10.1016/j.thromres.2020.11.039. Online ahead of print.

Safety and effectiveness of apixaban compared with warfarin among clinically-relevant subgroups of venous thromboembolism patients in the United States Medicare population

Guo JD, Hlavacek P, Rosenblatt L, et al.

BACKGROUND: The AMPLIFY trial found significantly lower major bleeding (MB) and similar recurrent venous thromboembolism (VTE) risks associated with apixaban vs warfarin among patients with VTE.

OBJECTIVES: To compare MB, clinically-relevant non-major (CRNM) bleeding, and recurrent VTE risks among clinically-relevant subgroups of newly diagnosed elderly patients with VTE prescribed apixaban vs warfarin.

METHODS: US Medicare patients prescribed apixaban or warfarin within 30 days post-VTE encounter were identified. Propensity score matching (PSM) was used to control for patient characteristics. Cox models were used to assess MB, CRNM bleeding, and recurrent VTE. Subgroup analyses were conducted for index VTE encounter type, index VTE diagnosis type, index VTE etiology, sex, and frailty.

RESULTS: Post-PSM, 11,363 matched pairs of patients prescribed apixaban or warfarin were identified. Apixaban had lower MB (Hazard Ratio [HR]:0.76; 95% CI:0.64-0.91) and similar recurrent VTE risks (HR:1.04; 95% CI:0.75-1.43) vs warfarin. No significant interactions were observed between treatment and index VTE encounter type, index VTE diagnosis type, or sex for risk of MB, CRNM bleeding, or recurrent VTE. Significant interactions: frail patients prescribed apixaban had a 15% lower, while non-frail patients prescribed apixaban had 32% lower CRNM bleeding risk vs those prescribed warfarin. Patients with provoked VTE prescribed apixaban trended toward a higher, while those with unprovoked VTE trended toward a lower risk of recurrent VTE vs patients prescribed warfarin.

CONCLUSIONS: Apixaban was associated with significantly lower risks of MB and CRNM bleeding, and similar risk of recurrent VTE as compared with warfarin across the overall population and most subgroups.

Am J Hypertens. 2020 Jan 1;33(1):26-30. doi: 10.1093/ajh/hpz118.

Impact of clinic-based blood pressure approaches on blood pressure measurement

Juraschek SP, Ishak A, Mukamal KJ, et al.

BACKGROUND: Clinic-based blood pressure (BP) is a closely-tracked metric of health care quality, but is prone to inaccuracy and measurement imprecision. Recent guidelines have advocated for automated office blood pressure (AOBP) devices to improve clinic-based BP assessments.

METHODS: Patients from a single hypertension clinic underwent a 3-day evaluation that included a 24-hour ambulatory blood pressure monitoring (ABPM), 2 manual clinic-based BP measurements (over 2 visits), and an unattended AOBP measurement (single visit). All measurements were compared to the average wake-time systolic BP (SBP) and diastolic BP (DBP) from ABPM.

RESULTS: Among 103 patients (mean age 57.3 ± 14.8 years, 51% women, 29% black) the average wake-time SBP was 131.3 ± 12.3 mm Hg and DBP was 78.3 ± 9.2 mm Hg. The average of 2 manual BPs was significantly higher than wake-time ABPM with mean differences of 5.5 mm Hg (P < 0.001) for SBP and 2.7 mm Hg (P = 0.002) for DBP. In contrast, the averages of the last 2 AOBP measurements did not significantly differ from ABPM with mean differences of 1.6 mm Hg (P = 0.21) for SBP and -0.5 mm Hg (P = 0.62) for DBP. The estimated prevalence of SBP ≥ 140 or DBP ≥ 90 mm Hg based on wake-time ABPM was 27.2% vs. 49.5% based on the average of 2 manual measurements (difference 22.3%; P < 0.001) and 31.1% based on the average of the last 2 AOBP measurements (difference 3.9%; P = 0.57).

CONCLUSIONS: A single visit, unattended AOBP more precisely estimated BP and the prevalence of stage 2 and uncontrolled hypertension than even the average of 2 manual clinic visits, supporting guideline recommendations to use AOBP for clinic-based BP measurements.

Am J Hypertens. 2020 May 21;33(6):563-569. doi: 10.1093/ajh/hpaa026.

The effects of mat Pilates training on vascular function and body fatness in obese young women with elevated blood pressure

Wong A, Figueroa A, Fischer SM, et al.

BACKGROUND: Effective nonpharmacological interventions targeting the enhancement of vascular function and decline of body fatness (BF) in obese individuals are indispensable for the prevention of hypertension and cardiovascular events in young adults. Mat Pilates training (MPT) has gained significant popularity worldwide,

yet its effects on vascular function and body composition are understudied. We examined the effects of MPT on vascular function and BF in young obese women with elevated blood pressure (BP).

METHODS: Twenty-eight young obese women with elevated BP were randomized to an MPT (n = 14) or a nonexercising control (CON, n = 14) group for 12 weeks. Systemic arterial stiffness (brachial-ankle pulse wave velocity (baPWV)), brachial and aortic BP, wave reflection (augmentation index (AIx)), plasma nitric oxide (NO) levels, and BF percentage (BF%) were assessed before and after 12 weeks.

RESULTS: MPT significantly reduced (P<0.05) baPWV (-0.7 ± 0.2 m/s), AIx (-4 ± 1%), brachial systolic BP (-5 ± 1 mm Hg), aortic systolic BP (-6 ± 1 mm Hg), and BF% (-2 ± 1%), while significantly increasing plasma NO (6 ± 2 µM) (P<0.05) compared with CON. MPT improved systemic arterial stiffness, aortic BP, wave reflection, circulating plasma NO, and BF% in young obese women with elevated BP.

CONCLUSIONS: MPT may be an effective intervention for the improvement of vascular function and BF in young obese women with elevated BP, a population at risk for hypertension and early vascular complications.

J Asthma. 2020 Dec 22;1-13. doi: 10.1080/02770903.2020.1862184. Online ahead of print.

Community health workers providing asthma education

Shaak S, Brown K, Reichart C, et al.

OBJECTIVES: Children living in urban areas experience disproportionate rates of asthma. Substandard housing conditions in some urban areas contribute to greater exposure to household asthma triggers. This article examines the geographic connection between pediatric asthma and substandard housing in one mid-sized city in Pennsylvania and the effectiveness of a home-based Community Health Worker (CHW) intervention targeted at this high-risk area to improve families› abilities to manage their children›s asthma.

METHODS: The CHWs provided education and resources to families of children diagnosed with mild, moderate or severe persistent asthma. A pre and post-test design was implemented to evaluate if the CHW intervention improved the family's ability to successfully manage their child's asthma. Eighty-one patients completed the program over a six-month period.

RESULTS: Results showed significant improvements in the areas of asthma knowledge, fewer missed days of school, fewer days with asthma symptoms, reduction in wheezing and fewer sleep disturbances. There was also a significant decrease in the number of Emergency Department visits and hospital days.

CONCLUSIONS: By teaching asthma management skills and by addressing in-home triggers, home-based CHW led interventions can be an affordable and effective way for caregivers and children with asthma to improve asthma management.

Am J Kidney Dis. 2020 Nov 22;S0272-6386(20)31073-8. doi: 10.1053/j.ajkd.2020.09.010. Online ahead of print.

KDOQI US Commentary on the 2020 ISPD Practice Recommendations for Prescribing High-Quality Goal-Directed Peritoneal Dialysis

Teitelbaum I, Glickman J, Neu A, et al.

The recently published 2020 International Society for Peritoneal Dialysis (ISPD) practice recommendations regarding prescription of high-quality goal-directed peritoneal dialysis differ fundamentally from previous guidelines that focused on "adequacy" of dialysis. The new ISPD publication emphasizes the need for a person-centered approach with shared decision making between the individual performing peritoneal dialysis and the clinical care team while taking a broader view of the various issues faced by that individual. Cognizant of the lack of strong evidence for the recommendations made, they are labeled as "practice points" rather than being graded numerically. This commentary presents the views of a work group convened by the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (KDOQI) to assess these recommendations and assist clinical providers in the United States in interpreting and implementing them. This will require changes to the current clinical paradigm, including greater resource allocation to allow for enhanced services that provide a more holistic and person-centered assessment of the quality of dialysis delivered.

MMWR Morb Mortal Wkly Rep. 2020 Dec 18;69(50):1902-1905. doi: 10.15585/mmwr.mm6950a4.

Telehealth practice among health centers during the COVID-19 Pandemic–United States, July 11-17, 2020

Demeke HB, Pao LZ, Clark H, et al al.

Early in the coronavirus disease 2019 (COVID-19) pandemic, in-person ambulatory health care visits declined by 60% across the United States, while telehealth visits increased, accounting for up to 30% of total care provided in some locations (1,2). In March 2020, the Centers for Medicare & Medicaid Services (CMS) released updated regulations and guidance changing telehealth provisions

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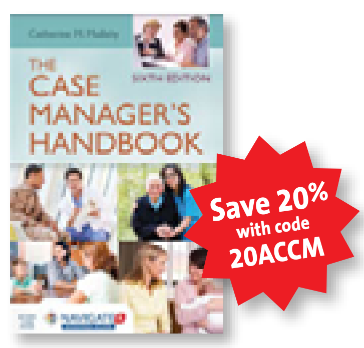

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during the COVID-19 Public Health Emergency, including the elimination of geographic barriers and enhanced reimbursement for telehealth services (3-6). The Health Resources and Services Administration (HRSA) administers a voluntary weekly Health Center COVID-19 Survey to track health centers› COVID-19 testing capacity and the impact of COVID-19 on operations, patients, and staff. CDC and HRSA analyzed data from the weekly COVID-19 survey completed by 1,009 HRSA-funded health centers (health centers) for the week of July 11–17, 2020, to describe telehealth service use in the United States by U.S. Census region, urbanicity, staffing capacity, change in visit volume, and personal protective equipment (PPE) supply. Among the 1,009 health center respondents, 963 (95.4%) reported providing telehealth services. Health centers in urban areas were more likely to provide >30% of health care visits virtually (i.e., via telehealth) than were health centers in rural areas. Telehealth is a promising approach to promoting access to care and can facilitate public health mitigation strategies and help prevent transmission of SARS-CoV-2 and other respiratory illnesses, while supporting continuity of care. Although CMS›s change of its telehealth provisions enabled health centers to expand telehealth by aligning guidance and leveraging federal resources, sustaining expanded use of telehealth services might require additional policies and resources.

Clin Infect Dis. 2020 Dec 14;ciaa1848. doi: 10.1093/cid/ciaa1848. Online ahead of print.

Understanding drivers of COVID-19 racial disparities: a population-level analysis of COVID-19 testing among black and white populations

Mody A, Pfeifauf K, Bradley C, et al.

BACKGROUND: Disparities in COVID-19 testing-the pandemic's most critical but limited resource-may be an important but modifiable driver of COVID-19 inequities.

METHODS: We analyzed data from the Missouri State Department Health and Senior Services on all COVID-19 tests conducted in the St. Louis and Kansas City regions. We adapted a well-established tool for measuring inequity-the Lorenz curve-to compare COVID-19 testing rates per diagnosed case among Black and White populations.

RESULTS: Between 3/14/2020 and 9/15/2020, 606,725 and 328,204 COVID-19 tests were conducted in the St. Louis and Kansas City regions, respectively. Over time, Black individuals consistently had approximately half the rate of testing per case compared to White individuals. In the early period (3/14/2020 to 6/15/2020), zip codes in the lowest quartile of testing rates accounted for only 12.1% and 8.8% of all tests in the St. Louis and Kansas City regions, respectively, even though they accounted for 25% of all cases each region. These zip codes had higher proportions of residents who were Black, without insurance, and with lower median incomes. These disparities were reduced but still persisted during later phases of the pandemic (6/16/2020 to 9/15/2020). Lastly, even within the same zip code, Black residents had lower rates of tests per case compared to White residents.

CONCLUSIONS: Black populations had consistently lower COVID-19 testing rates per diagnosed case compared to White populations in two Missouri regions. Public health strategies should proactively focus on addressing equity gaps in COVID-19 testing to improve equity of the overall response.

N Engl J Med. 2020 Dec 17. doi: 10.1056/NEJMoa2030340. Online ahead of print.

Tocilizumab in patients hospitalized with Covid-19 pneumonia

Salama C, Han J, Yau L, et al.

BACKGROUND: Coronavirus disease 2019 (Covid-19) pneumonia is often associated with hyperinflammation. Despite the disproportionate incidence of Covid-19 among underserved and racial and ethnic minority populations, the safety and efficacy of the anti-interleukin-6 receptor antibody tocilizumab in patients from these populations who are hospitalized with Covid-19 pneumonia are unclear.

METHODS: We randomly assigned (in a 2:1 ratio) patients hospitalized with Covid-19 pneumonia who were not receiving mechanical ventilation to receive standard care plus one or two doses of either tocilizumab (8 mg per kilogram of body weight intravenously) or placebo. Site selection was focused on the inclusion of sites enrolling high-risk and minority populations. The primary outcome was mechanical ventilation or death by day 28.

RESULTS: A total of 389 patients underwent randomization, and the modified intention-to-treat population included 249 patients in the tocilizumab group and 128 patients in the placebo group; 56.0% were Hispanic or Latino, 14.9% were Black, 12.7% were American Indian or Alaska Native, 12.7% were non-Hispanic White, and 3.7% were of other or unknown race or ethnic group. The cumulative percentage of patients who had received mechanical ventilation or who had died by day 28 was 12.0% (95% confidence interval [CI], 8.5 to 16.9) in the tocilizumab group and 19.3% (95% CI, 13.3 to 27.4) in the placebo group (hazard ratio for mechanical ventilation or death, 0.56; 95% CI, 0.33 to 0.97; P = 0.04 by the log-rank test). Clinical failure as assessed in a time-to-event analysis favored tocilizumab over placebo (hazard ratio, 0.55; 95% CI, 0.33 to 0.93). Death from any cause by day 28 occurred in 10.4% of the patients in the tocilizumab group and 8.6% of those

continues on page 39

Embracing an Unpredictable Future: Issues and Challenges
continued from page 2

Racism and social justice: Racism has been called a public health problem. The COVID-19 pandemic highlighted racial disparities of care and the relevance of social determinants of health. In 2021, with social movements serving as an accelerant, we should expect demands for remediation of systemic racism and other root causes of disparities of care to gain in importance. Governing bodies and management staff will need to focus on diversity and understand management efforts to combat racism and reduce disparities of care. Everyone must work together.

Increased demands for mental health services: Virtual homeschooling, staying safe, financial hardships, teleworking, keeping up with new information, coping with sickness and death, as well as isolation and loneliness are contributing factors leading to an increased demand for mental health services. The negative effects of mental health issues became all too real in 2020. According to a MetLife Navigating Together study, 2 in 3 employees state that they are feeling more stressed than before the COVID-19 pandemic. Further, 73% of employees said reducing employee stress was a key objective. How people manage stress is critical to finding respite from the pandemic. Programs that can reduce stress include flexible work arrangements, mental wellness programs, eating a healthy diet, and getting adequate sleep—in other words taking care of yourself and others.

New and improved systems: Artificial intelligence (AI) is one of the biggest technology trends and will continue for 2021. It will become an even more valuable tool for helping to interpret and understand the world around us. The volume of data we are collecting is overwhelming. This means that machine learning algorithms will become better informed and increasingly sophisticated, all in an effort to improve patient outcomes.

Getting effective tools to everyone who needs them will be key to ending this first acute phase of the pandemic and to solve the health and economic crises it has caused.

The need for efficiency and touch-free interactions may boost clinical use of natural language processing—a branch of AI that allows computers to understand spoken remarks—by seamlessly transmitting data into a patient's electronic health record. Automated services such as symptom-checking chatbots will continue to ease administrative bottlenecks.

Knowledge: The demand for knowledge across the health care spectrum will continue. Research will bring new treatments and understanding of disease, all in an effort to improve patient outcomes. One of the biggest changes and challenges will be the acquisition of knowledge. Seminars, conference, and study groups all have changed to a virtual platform. For the most part, virtual learning has had many benefits. For example, virtual learning has improved access to knowledge. People no longer have to travel to a conference, they just have to log on to a website. You can attend the conference when it is convenient rather than when the conference was scheduled. Technology has effectively been used to introduce virtual learning. In the future, we will see a hybrid approach to learning and acquiring knowledge. Self-study, video conferences, podcasts, and things we haven't even thought of will be in our future.

Case managers can embrace the unpredictable future. The COVID-19 pandemic has significantly influenced health care as well as social justice. In 2021, we will continue to experience a high level of stress, but it will be a good year. The COVID-19 vaccination process will accelerate. Yes, we will experience a "new normal." Let us look forward to 2021 with hope, resilience, and a commitment to providing the best case management possible to improve outcomes for our patients.

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

ACCM: Improving Case Management Practice through Education

The Future of Care Coordination and Case Management in the Veterans Health Administration

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long that infrastructure reorganization requires the recruitment of personnel interested in working with the whole patient, willing to learn and apply new skills, having the personal attributes needed to work on integrated case management teams."..."[1]

A national initiative established within the VHA is now revolutionizing care coordination and case management across the care continuum. This enterprisewide framework creates a culture that endorses standards and fosters uniformity in care coordination processes, ensuring that all at-risk veterans have access to high-quality care coordination. This system supports the veteran experience, builds trust and enhances safety, and ultimately, improves the veteran-VA provider relationship.

VHA has an abundance of cutting-edge programs that deliver innovative care coordination services to Service members and veterans. However, these services have historically been delivered in a fragmented manner with care coordination and case management disciplines working in silos across the healthcare continuum. This fragmentation can create unnecessary duplication of services as well as service delivery gaps for VA, the nation's largest integrated health care system. Over the past two decades, specialized care coordination services have focused on high-risk veteran populations, yielding positive outcomes in focused areas only. This approach was beneficial to veterans who met program eligibility but was unhelpful to veterans who did not meet program eligibility criteria.

Care coordination services, including case management, must be synchronized along the health care continuum to stratify coordination according to healthcare complexity, across levels of care. This risk-stratification approach promotes optimal health outcomes and effective utilization of VHA and community resources. VHA provides case management services to assist eligible service members and veterans, who have complex chronic care needs and socio-economic vulnerabilities, through systems navigation, care coordination, and biopsychosocial rehabilitation. Case Management services are delivered within specific clinical programs and service areas, and eligibility is determined by population and condition-based criteria. As a growing number of VHA-enrolled veterans seek care in the community, it is vital that VHA strengthen and integrate care coordination services and resources.

Care coordination and case management services are critical components to ensuring veterans can access care within the nation's largest integrated health care system.

To address these the Offices of Nursing Services (ONS) and Care Management and Social Work (CMSW) partnered and co-sponsored an Integrated Case Management Initiative (Care Coordination and Integrated Case Management (CC&ICM) that aimed to define, transform, and integrate VHA case management. The initiative's work identified and expanded upon internal, program-specific, and private sector Case Management best practices as well as contextualized Case Management within a broader Level of Care Coordination framework. The result of this nationwide effort is a National CC&ICM framework. The framework contains best practices in the areas of care coordination and case management and is designed to keep pace with breakthroughs that emerge through ongoing process improvement.

The CC&ICM framework is defined as a specialized, collaborative practice among multiple healthcare professions. CC&ICM provides structure and standards to support interprofessional collaboration throughout the healthcare continuum and optimizes utilization of healthcare resources. It addresses physical, mental health and psychosocial needs to enhance veterans' wellness, level of functioning, and quality of life. The aim is to provide integrated safe, efficient, and cost-effective interventions, while improving healthcare access, and reducing duplication and fragmentation of services.

The CC&ICM framework integrates care at the organizational and systems levels in order to create and strengthen the continuum of care for patients at high risk and professional standards of practice for VA care coordination staff. **CM**

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***Melanie Rouch,** LCSW, and **Dorothy Sanders, BSN, RN, CCM,** are field advisors at Care Coordination & Integrated Case Management (CC&ICM), U.S. Department of Veterans Affairs. **Elizabeth Sprinkle, LCSW,** is a program manager at CC&ICM, U.S Department of Veterans Affairs. **Adrienne Weede, LCSW,** is the National Program Manager–Transition & Care Management, U.S. Department of Veterans Affairs. **Lisa Perla, MSN, FNP, CNRN, CRRN, CCM, PhD (candidate)**, is the National Polytrauma Coordinator, U.S. Department of Veterans Affairs.*

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in the placebo group (weighted difference, 2.0 percentage points; 95% CI, -5.2 to 7.8). In the safety population, serious adverse events occurred in 38 of 250 patients (15.2%) in the tocilizumab group and 25 of 127 patients (19.7%) in the placebo group.

CONCLUSIONS: In hospitalized patients with Covid-19 pneumonia who were not receiving mechanical ventilation, tocilizumab reduced the likelihood of progression to the composite outcome of mechanical ventilation or death, but it did not improve survival. No new safety signals were identified.

Ann Intern Med. 2020 Dec 8;M20-6519. doi: 10.7326/M20-6519. Online ahead of print.

Hydroxychloroquine as postexposure prophylaxis to prevent severe acute respiratory syndrome coronavirus 2 infection : a randomized trial

Barnabas RV, Brown ER, Bershteyn A, et al.

BACKGROUND: Effective prevention against coronavirus disease 2019 (COVID-19), caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), is currently limited to nonpharmaceutical strategies. Laboratory and observational data suggested that hydroxychloroquine had biological activity against SARS-CoV-2, potentially permitting its use for prevention.

OBJECTIVE: To test hydroxychloroquine as postexposure prophylaxis for SARS-CoV-2 infection.

DESIGN: Household-randomized, double-blind, controlled trial of hydroxychloroquine postexposure prophylaxis. (ClinicalTrials.gov: NCT04328961). Setting: National U.S. multicenter study.

PARTICIPANTS: Close contacts recently exposed (<96 hours) to persons with diagnosed SARS-CoV-2 infection.

INTERVENTION: Hydroxychloroquine (400 mg/d for 3 days followed by 200 mg/d for 11 days) or ascorbic acid (500 mg/d followed by 250 mg/d) as a placebo-equivalent control.

MEASUREMENTS: Participants self-collected mid-turbinate swabs daily (days 1 to 14) for SARS-CoV-2 polymerase chain reaction (PCR) testing. The primary outcome was PCR-confirmed incident SARS-CoV-2 infection among persons who were SARS-CoV-2 negative at enrollment.

RESULTS: Between March and August 2020, 671 households were randomly assigned: 337 (407 participants) to the hydroxychloroquine group and 334 (422 participants) to the control group. Retention at day 14 was 91%, and 10 724 of 11 606 (92%) expected swabs were tested. Among the 689 (89%) participants who were SARS-CoV-2 negative at baseline, there was no difference between the hydroxychloroquine and control groups in SARS-CoV-2 acquisition by day 14 (53 versus 45 events; adjusted hazard ratio, 1.10 [95% CI, 0.73 to 1.66]; P > 0.20). The frequency of participants experiencing adverse events was higher in the hydroxychloroquine group than the control group (66 [16.2%] versus 46 [10.9%], respectively; P = 0.026).

LIMITATION: The delay between exposure, and then baseline testing and the first dose of hydroxychloroquine or ascorbic acid, was a median of 2 days.

CONCLUSION: This rigorous randomized controlled trial among persons with recent exposure excluded a clinically meaningful effect of hydroxychloroquine as postexposure prophylaxis to prevent SARS-CoV-2 infection

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Headlines in Real Life

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30 days each to help the blood reestablish its ability to clot. When we submitted the prescription for the first patient, the pharmacy benefit manager (PBM) denied it due to the high dosage (up to 30 tablets per day for up to 6 months, which under normal circumstances would be lethal as well).

The case manager sent the physician notes and a copy of the current news stories to the PBM and asked for reconsideration. This was denied as well. Same scenario for the other 2 patients. Out of pocket cost without using a patient's insurance ran into several thousands of dollars for the duration of the treatment. Not an option for any of my patients.

I called the IDPH and asked what, if anything, could be done. Mine was not the only call they had received on this issue. They responded that they were working on access to treatment. In the meantime, the patients needed to stay in the hospital, receiving the high dose Vitamin K therapy to counteract the poison. Day after day, I would follow up with IDPH and the team would report back to the trio of patients with any updates. Day after day, they would be disappointed, annoyed, aggravated and ultimately, accepting of yet another day in the hospital.

And then, one day, I received a call from the IDPH, with instructions for each of my patients on how to access free lifesaving treatment provided by the Bausch Foundation and Valeant Pharmaceuticals, who donated 800,000 tablets of Vitamin K for this public health emergency. My team was informed and each of the patients were given the great news along with the where, when, and how to access this program through the IDPH.

Exhaust all your resources and think creatively; you never know where the answer to your problem will come from. CM

Improving Hemoglobin A1C Using Diabetes Self-Management Education in a Free Clinic *continued from page 15*

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PharmaFacts for Case Managers

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Outlook 2021: Change Is Here to Stay
continued from page 5

yet to pursue case management as part of their career plans. We will continue our outreach to health and human services organizations that serve multiple diverse populations to promote case management as a career opportunity.

- **Constancy through crisis**. As case managers navigated the pandemic, certain foundational elements of the practice provided the necessary constancy through crisis. Among these resources are the Code of Professional Conduct for Case Managers and NCCA accreditation standards, each promoting a high degree of ethical and professional behavior and practice. We also continue to be guided by our vision and mission: to be the global leader committed to the advancement and evolution of case management and to advocate for professional case management excellence through certification and interrelated programs and services. No matter how much the world changes, we are reminded of the importance of a strong foundation.
- **A deeper appreciation.** The list of those whom we appreciate is long: front-line essential workers; colleagues who connect and collaborate with us both in-person and virtually; family and friends, whose love and support means even more during difficult times; and so many others. On a personal note, I am deeply grateful for the volunteers, staff, and colleagues at the Commission and in the broader case management community. As a nonprofit organization, the Commission relies on the professionalism of our Commissioners, volunteers who give selflessly of their time and talent. These professionals, spanning both the CCM and CDMS credentials and our public members, are truly passionate about what they do. As we look to the challenges and opportunities in 2021 and beyond, the Commission is fortunate to have a robust group of Commissioners who are committed to the development of others.

Even as we put the pandemic behind us, the lessons learned from the COVID-19 crisis must not be forgotten. All that professional case managers and disability managers have experienced, seen, and learned will enhance the body of knowledge to further elevate the impact of these professions on the health and human services spectrum. CM

Fraud Enforcers Working More Closely Together *continued from page 10*

hundred attorneys and their agency clients within HHS

Although it is certainly difficult to assess how effective this Group will be in meeting the above goals, the activities of the Group are likely to place providers under even greater scrutiny for fraud and abuse compliance.

In response, providers must dust off their Fraud and Abuse Compliance Plans to make sure they are up-to-date and fully implemented. Providers that come under scrutiny will surely be asked to demonstrate their commitment to compliance through their Plans. They are also likely to be asked to show how much money they have spent on fraud and abuse compliance. Get ready now! CM

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Perspective! *continued from page 6*

and Parthenon Management Group have used the past 4 months to transform data into information critical to the advancement and evolution of the association. The reexamination of member needs, partner and sponsor value propositions, professional gaps, and innovative management style of our Association Management Company have resulted in a "new look" and "new perspective" for CMSA's mission and vision. We are working to simplify governance and clearly articulate how all of the pieces fit together. Each part is interconnected and creates a symbiotic relationship that makes the organization strong, action-oriented, and relevant. We are excited about our new structure as CMSA emerges into a new decade that requires agility, dynamic responsiveness, and an elevated level of member support like never before!

Perspective is revelatory, defining, and directional for any organization, but especially for CMSA as we embrace a new decade for professional case management. We are excited about the action-oriented, member-informed, and board-led approach to governance, strategy, and engagement in 2021. The internet, phone lines, and virtual doors are open for member feedback, industry input, and partner perspectives as we…together…drive innovation, value, and transformation for the case manager and case management profession. Let's do this! CM

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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
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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
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