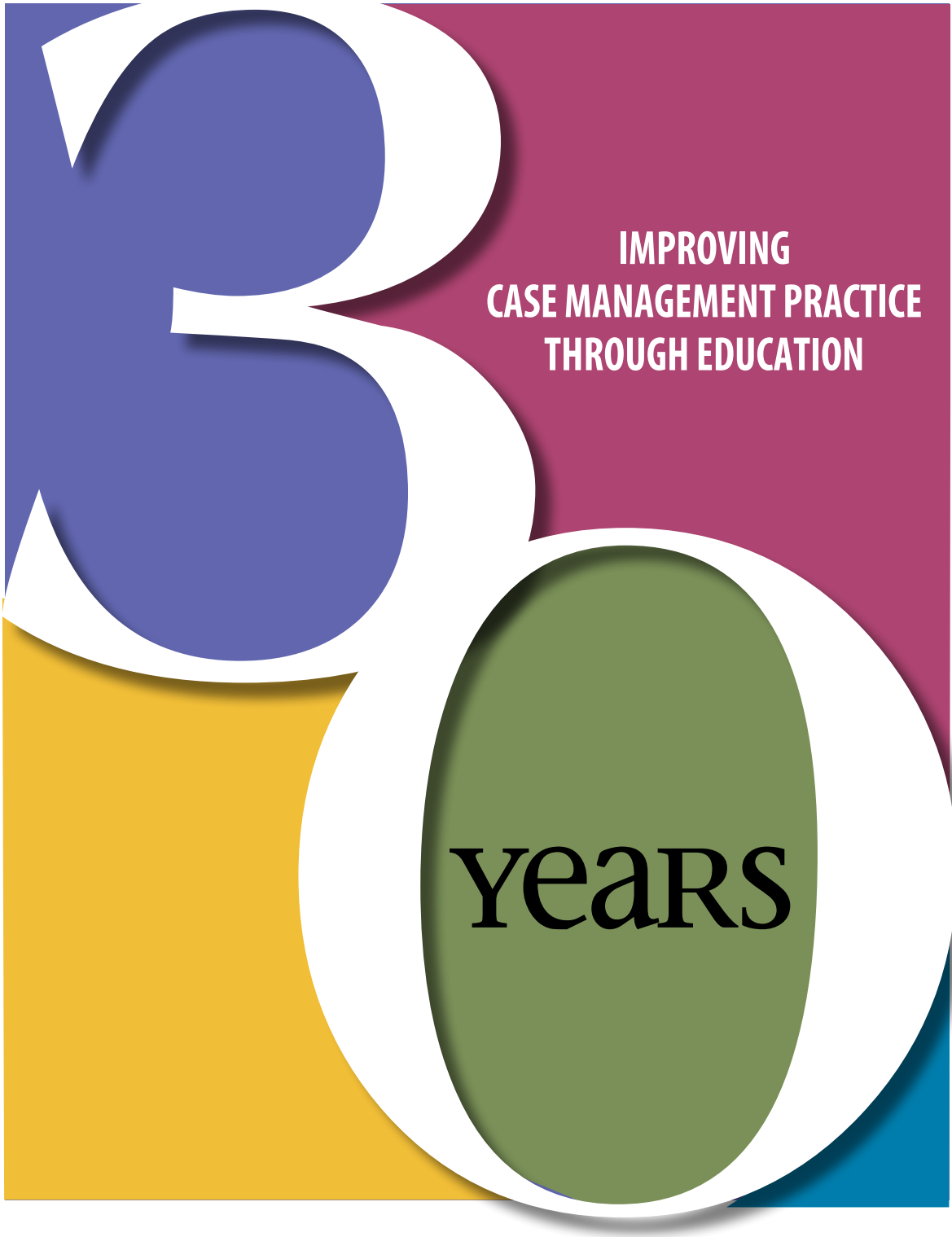
CareManagement

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

Vol. 31, No. 1 April/May 2025

celebrating



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Celebrating 30 Years

With this issue of *CareManagement*, we celebrate thirty years of publishing the journal. It is a remarkable achievement. We have survived and grown as we have witnessed significant changes in healthcare and publishing. From the outset, the mission of *CareManagement* has been to improve the professional practice of case management through education. A journal serves as a platform to publish stories, allowing the sharing of new knowledge, research, and clinical expression, ultimately contributing to improved patient care by providing a reliable source of information for the reader. Journals disseminate information, provide continuing education, and offer opinions and news. *CareManagement* has met that challenge and exceeded it, and this success is largely due to the invaluable contributions of our readers, authors, partners, and staff.

Howard Mason, RPh, MS, Publisher and President, deserves much credit for his idea for this publication for case managers. Howard Mason, in 1994, recognized the opportunity and need for case managers to be educated through a publication that offered quality continuing education. In April 1995, we published our first issue. Mason has a pharmaceutical industry and medical communications background and is a pharmacist by education. It was his idea, and he continues to generate ideas to make *CareManagement* what it is today. I have been associated with Mason as the Editor-in-Chief for these 30 years, and it has been a delight and privilege. Thank you, Howard!

The future is before us! Although we are currently faced with uncertainties in healthcare, we understand the challenges that you, our readers, and the entire healthcare community are facing.

The case manager readers are the lifeline of the journal. Every other month, *CareManagement* is distributed to thousands of case managers, bringing information to improve the professional practice of case management along with news from our partners, The Case Management Society of America and the Commission for Case Manager Certification and Certified Disability Management Specialists. Our primary focus is offering pre-approved continuing education, and in doing so, we have offered over 450 self-study courses and issued over 425,000 continuing education certificates. Self-study continuing education has allowed case managers to meet their continuing education needs for certification maintenance and gaining new, current knowledge in their setting, at their pace, at a reasonable fee. I give a huge shout-out of appreciation and thank you to all our readers!

The authors create the magic of

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CareManagement

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Catherine M. Mullahy

Collaboration…Overcoming Resistance and Achieving Success!

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

One of the essential elements of the case management process is collaboration. Today there is increased emphasis on the significance of interprofessional collaboration rather than functioning in silos separated from the expertise and perspectives of our colleagues. The WHO (World Health Organization) has defined this strategically important process as one that occurs when multiple health workers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver high-quality care to achieve the common goal of improved outcomes.

Some teams in diverse practice settings across the care continuum have become unwieldy and lack a shared vision and mission. While it's ideal to have a multidisciplinary team, especially with complex patients, it requires time and a willingness to allow each member opportunities to contribute. It is essential to assess the kind of educational preparation and experience that younger practitioners have had. Did they interact only with members of their profession, or did they work alongside other disciplines, which would allow them a broader understanding, not only of their role but those of others on their teams? Continuing interprofessional education can strengthen collaborative practice by helping prepare individuals to appreciate and understand other team members' roles. When there is enhanced knowledge of what others can do, the workload can be adjusted to the expertise of colleagues. This is especially true when nurses and social workers are on the same team. While they typically have complementary skills, they should function within their specific practice scope. Each professional should be working at the top of their license and feel comfortable seeking additional information to clarify the skillset and responsibilities of others on their team and within their scope of practice.

Interprofessional collaboration among different disciplines and sectors involved in the care and support of our clients can improve the quality, continuity, and comprehensiveness of our services and reduce the duplication, fragmentation, and gaps in the system....

Interprofessional collaboration among different disciplines and sectors involved in the care and support of our clients can improve the quality, continuity, and comprehensiveness of our services and reduce the duplication, fragmentation, and gaps in the system, which, unfortunately, are increasing. Interprofessional collaboration can also enhance learning, innovation, advocacy skills, and professional identity and satisfaction. To foster interprofessional collaboration, you must establish clearly defined roles, responsibilities, and expectations, share information and resources, and build trust and respect among team members.

While we should strive to achieve a win-win scenario, we occasionally face conflicting opinions on a complex case strategy. Have you thought about how these might be resolved? It's always advisable to have a process that will allow a discussion of the case, achievable solutions, and possible outcomes before encountering it, rather than scrambling for a "fix," often in a time-sensitive environment. A few recommendations might be helpful to keep in mind…or to rehearse much like a fire drill. Here they are for your consideration:

- **Facilitate open dialogue:** Encourage all parties to openly share their perspectives and concerns.
- **Seek common ground:** Identify overlapping goals and priorities to find a mutually acceptable path forward.
- **Employ data and evidence:** Use factual information to support decisions and reduce emotional biases.

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A Case Manager's Journey: Getting Certified, Staying Certified, Developing Others

By Margaret Ann Tindal Brown, DHA, RN, CCM

Although our experiences differ, we find common ground in case management at a time when these services are more important than ever to help stakeholders—consumers, payers, and providers—achieve their desired goals.

"HAVE YOU EVER CONSIDERED CASE MANAGEMENT?"

This question came out of the blue from an HR representative at the hospital where I worked. Little did I know it would change my life.

This change took place in early 2010, and though I was practicing as a registered nurse, my tenure was on the night shift, and I had very little exposure to case management. After consulting further with the HR representative, I decided to apply for the position and went through the interview process. My lack of familiarity would be a deterrent. Much to my surprise, I was offered the position and was quickly surrounded by a team of knowledgeable and caring professionals who showed me how to function in this new and exciting role. What I couldn't appreciate fully then was how becoming a professional case manager would enhance my career journey.

In my first case management position, I was assigned to both the hospital's certified stroke unit and joint replacement center. In both settings, education was critical to my role, especially for patients preparing for elective surgery. I learned how to build relationships with each individual and advocate for them based on their needs and goals.

Initially, my case management duties included utilization management; in fact, it was about half my job. This was in keeping with standard practice in case management at the time. However, case management would soon take me into new areas of practice. What I experienced was also reflected in changes in the field, as captured in the Commission for Case Manager Certification's field studies. The 2019 role and function study, for example, showed utilization review/management had begun evolving into a role that is increasingly separate from case management where a greater emphasis was being placed on care coordination.

My next significant move was into the hospital's clinically integrated network as the manager of care coordination. In this newly established role, I had the opportunity to build the care coordination program and offer it within a population health model wherein we serviced individuals at various levels of risk. The program provided health coaching, disease management, case management, and transitions of care support. In this position, I combined my clinical expertise with my love of public health, which was the concentration for my master's degree, and health administration, the focus of my doctorate.

Over time, the care coordination program expanded to include professional oversight of the case managers hired for the clinically integrated network and those employed by private practices. Looking back, I see how our model of care was corroborated by the Commission's field research into the importance of professional case managers taking greater responsibility for impactful care management, care coordination, and transitions of care roles.

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Margaret Ann Tindal Brown, DHA, RN, CCM, *is a newly elected Commissioner of the Commission for Case Manager Certification (CCMC), the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists. The Commission oversees the process of case manager certification with its CCM® credential and disability management specialist certification with its CDMS® credential. With a background as a registered nurse and a Doctor of Health Administration (DHA) degree from Central Michigan University, she has held several case management roles in acute and ambulatory care. She is currently Senior Director, Care Management for Priority Health.*

The Case Management Society of America (CMSA) Celebrates Its 35th Anniversary

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

The CMSA is set to commemorate its 35th anniversary with the Annual Conference & Expo, scheduled for June 24–27, 2025, at the Hilton Anatole in Dallas, Texas. This milestone event, themed "Case Management: Innovative Solutions, Improved Outcomes," promises to be the premier gathering for professionals dedicated to case management excellence and innovation.

Event Overview

The CMSA Annual Conference & Expo is renowned for offering a comprehensive platform for education, networking, and professional development. As the organization celebrates 35 years, the 2025 conference aims to reflect on the legacy of case management, celebrate achievements, and chart the profession's future. This event will highlight advancements in the field and honor the critical role that case managers play in healthcare.

Celebrating the Profession of Case Management

The conference will celebrate the case management profession and its profound impact on the healthcare system. We are the unsung heroes who bridge gaps in care, coordinate complex treatment plans, and ensure patients receive the proper care at the right time. Our work drives exceptional patient outcomes, enhances patient safety, and navigates patients through their healthcare journeys.

Throughout the event, CMSA will recognize and honor the dedication, resilience, and expertise of case managers. Special recognition ceremonies and awards will highlight those who have contributed significantly to the field. Stories of patient advocacy, innovative care coordination, and impactful leadership will be shared, inspiring attendees and reinforcing the profession's value.

Sessions and discussions will explore how case management contributes to all care models, highlighting our alignment with broader healthcare goals of quality improvement and cost efficiency.

Key Highlights

- **Educational Sessions:** Attendees can anticipate a diverse range of sessions led by industry experts, focusing on the latest trends, best practices, and innovative solutions in case management. Topics are expected to cover areas including the impact of social determinants of health, technological advancements, and strategies for effective care transitions.
- **Networking Opportunities:** The conference will facilitate numerous opportunities for professionals to connect, share insights, and build relationships. Special Interest Groups (SIGs) focusing on International, Military/VA/DoD, and Rural Case Management will host networking sessions, providing valuable platforms for members to engage in meaningful discussions. And the popular Networking Roundtables will return!
- **Exhibit Hall:** An engaging exhibit hall will showcase the latest innovations and solutions in case management, allowing attendees to explore new tools and resources that can enhance their practice. I always find at least one new tool in the exhibit hall to improve my practice!
- **Celebratory Events:** To mark the 35th anniversary, we have planned special events to celebrate the achievements of CMSA and its members, reflect on the organization's legacy, and envision the future of case management.

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Colleen Morley-Grabowski, DNP, RN, CCM, CMAC, CMCN, ACM-RN, FCM, *is Immediate Past President of the Case Management Society of America National Board of Directors and principal of Altra Healthcare Consulting in CO.*

Legal Updates

By Elizabeth E. Hogue, Esq.

Court Decision Is Another Boost for Care at Home

In Olmstead v. L.C., the U.S. Supreme Court decided that unjustified segregation of disabled persons constitutes discrimination in violation of Title II of the Americans with Disabilities Act.

The Court said that public entities must provide community-based services to disabled persons when such services are:

- Appropriate
- Unopposed by disabled persons
- Reasonable accommodation that takes into account resources available to public entities and the needs of other disabled individuals receiving services from the entity

This decision greatly boosted the provision of home and community-based services of all types. Since Olmstead was decided in 1999, more court decisions have required services to be provided at home based on this opinion.

One recent decision in Brown et al. v. District of Columbia was decided on December 31, 2024. The Court agreed that the District of Columbia violated the rights of DC residents with disabilities under the Americans with Disabilities Act (ADA) and the Rehabilitation Act. According to the Court, DC failed to inform nursing facility residents who receive Medicaid that they could leave nursing facilities and receive home health services in their communities and failed to assist them in doing so. The DC government also failed to help them access community-based services and housing options needed to transition back to the community.

The Court recognized that individuals in nursing facilities often need help learning about and applying for available community services to help them transition out of the institution and into their homes. Even when residents learn about services, navigating the complicated Medicaid-funded long-term care program can cause confusion and anxiety that sometimes causes facility residents to lose hope that they can live in their own homes again.

Consequently, the decision applies to:

"All persons with physical disabilities who, now or during the pendency of this lawsuit: (1) receive DC Medicaid-funded long-term care services in a nursing facility for 90 or more consecutive days; (2) are eligible for Medicaid-covered home and community-based long-term care services that would enable them to live in the community; and (3) would prefer to live in the community instead of a nursing facility but need the District of Columbia to provide transition assistance to facilitate their access to long-term care services in the community."

The Court said that DC must:

1. Develop and implement a working system of transition assistance for [nursing home residents that], at a minimum: (a) informs DC Medicaid-funded residents, upon admission and at least every three months thereafter, about community-based long-term care alternatives to nursing facilities; (b) elicits DC Medicaid-funded nursing facility residents' preferences for community or nursing facility placement upon admission and at least every three months thereafter; (c) begins DC Medicaid-funded nursing facility residents' discharge planning upon admission and reviews at least every month the progress made on that plan, and (d) provides DC Medicaid-funded nursing facility residents who do not oppose living in the community with assistance accessing all appropriate resources available in the community.
2. Ensure sufficient capacity of community-based long-term care services for [residents] under the EPD, MFP, and PCA programs and other long-term care service programs to serve [residents] in the most integrated setting appropriate to their needs, as measured by enrollment in these long-term care programs.
3. …[D]emonstrate [its] ongoing commitment to deinstitutionalization by, at a minimum, publicly reporting on at least a semi-annual basis the total number of DC Medicaid-funded nursing facility residents who do not oppose living in the community; the number of those individuals assisted by [DC] to transition to the community with long-term care services [described above]; and the aggregate dollars [DC] saves (or fails to save) by serving individuals in the community rather than in nursing facilities.

As indicated above, there continues to be a clear mandate for Medicaid Programs to provide services to individuals in the community, which is a significant impetus for providing services to patients in their homes. This mandate, however, does not directly address practical aspects of implementation, such as reimbursement at appropriate rates for providers or the availability of staff to provide services at home. Nonetheless, the Olmstead and Brown cases provide an important basis for further development of in-home services of all types to meet the needs of disabled persons. ■

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

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Empower Case Managers to Address Workplace Bullying

By Renn Thompson, DNP, RN, FAAN, CSP; Cheryl Fletcher, MSN, RN, NPD-BC

As a case manager, I worked for a managed care organization, providing members with comprehensive disease management services. We had programs for chronic obstructive pulmonary disease (COPD) and Heart Failure, among others. I recall authorizing numerous scales for our heart failure patients and ensuring our respiratory providers had plenty of nebulizers for those who needed them. We also collaborated with healthcare providers to ensure patients with diabetes received appropriate care. We aimed to offer support, or so I thought.

However, being associated with a managed care company, often perceived as the adversary, sometimes made my job challenging. When I arrived at provider sites and introduced myself, mentioning my company's name usually elicited a noticeable shift in demeanor. A once friendly reception could quickly turn into eye-rolls or looks of immediate dread, followed by long, prolonged waiting times.

The negative treatment I encountered was surprising since I aimed to assist healthcare providers in caring for their patients. Nevertheless, my affiliation with a managed care company made some view me as a source of their problems. A few office managers even took the opportunity to vent their frustrations, criticizing everything they disagreed with.

Years later, I assumed a coordinator role in a neurosurgical step-down unit. My role involved rounding with neurosurgeons early in the morning and meeting with case managers and social workers to discuss patient treatment plans. In this position, I witnessed similar acts of disrespect and outright overt incivility toward case managers from physicians, nurses, patients, and families.

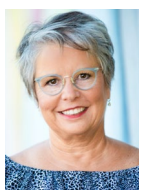
For example, when a case manager informed a neurosurgeon that their patient didn't qualify for rehab, the physician berated them in the hallway, saying, "Guess you don't know how to do your job!" Another time, a family member kicked the case manager and social worker out of their father's room after being informed that their insurance didn't cover the equipment they wanted.

I've experienced and witnessed case managers being excluded from interprofessional rounds, almost pushed out of the circle, treated condescendingly, ignored, and subjected to yelling, cursing, and threats. Despite their crucial role in primary and acute care settings, case managers often find their contributions undervalued and dismissed by others. They are frequently seen as an annoyance or interruption and not always treated with respect by the healthcare team, patients, and their families.

Literature Review

While there's limited literature explicitly addressing the prevalence of incivility and bullying directly impacting case managers, research clearly shows that these behaviors are on the rise. A recent study by the Society for Human Resource Management, which included over 1,600 U.S. employees, found that 66% had experienced or witnessed incivility at work within the past month and 57% within the past week. The most common forms of incivility reported were disrespectful communication (36%), interruptions (34%), and excessive micromanagement (32%). Additionally, only a

Renee Thompson, DNP, RN, FAAN, CSP, *Recognized as an international expert and thought leader on creating a healthy nursing workforce by eradicating workplace bullying and incivility, Dr. Renee Thompson is a prominent speaker, consultant, author, and social media influencer. With more than 32 years as a clinical nurse, nurse educator, and nurse executive, Dr. Thompson is well respected by the nursing community for her evidence based, practical strategies to address workplace bullying and incivility and create cultures of professionalism and respect.*



Cheryl Fletcher, MSN, RN, NPD-BC, *strategic consultant and learning development expert specializing in workforce development, data driven decisions, and program optimization. Skilled in guiding organizations through complex challenges to enhance learning, engagement, and retention. Proven ability to design and implement scalable solutions that drive cultural transformation and operational excellence.*

While there's limited literature explicitly addressing the prevalence of incivility and bullying directly impacting case managers, research clearly shows that these behaviors are on the rise.

TABLE 1 FREQUENCY OF WORKPLACE INCIVILITY

Source	% of incidents
Patient families	58%
Nurses	57%
Patients	54%
Physicians	47%
Manager or supervisors	30%
Other team members	25%
Administration	24%

AONL Longitudinal Study (2023)

quarter of these employees believed their managers effectively handled such issues, highlighting a significant gap in leadership effectiveness.

Adding to this concern, a 2022 survey by Christine Porath of 2,000 global workers (Table 1) revealed that 76% experienced or witnessed workplace incivility at least once a month, with 78% noting an increase in bad behavior from clients towards employees over the past five years. A recent AONL Longitudinal study (2023) highlighted the sources of bullying or incivility healthcare professionals face. This data underscores the growing concern about the prevalence and management of incivility in both the workplace and interpersonal interactions.

The 2015 ANA Position Statement on Incivility, Bullying, and Workplace Violence emphasizes our collective responsibility to foster a culture of respect, free of incivility and violence. Both RNs and employers hold ethical, moral, and legal obligations to ensure a safe and healthy work environment for all healthcare team members, patients, families, and communities. Additionally, the ANA Code of Ethics for Nurses (2015) and the Code of Professional Conduct for Case Managers (2023) mandate that nurses create an environment of civility and kindness, treating everyone with dignity and respect.

Getting Clear

Disruptive behavior, bullying, and incivility often describe unacceptable conduct within the healthcare environment. While these behaviors share similarities, they each represent distinct forms of negative behavior that must be understood and addressed. This article explores the differences between disruptive behavior, incivility, and bullying, highlighting the importance of recognizing and managing these behaviors to maintain a healthy work environment in healthcare.

Disruptive Behavior

Disruptive behavior refers to actions that cause interruptions or divide the workplace. In healthcare, this disruptive behavior typically involves behaviors or attitudes that hinder the smooth delivery of care, affecting patient outcomes and team dynamics. According to the Joint Commission (2021), disruptive behaviors include:

- Reluctance or refusal to answer questions, return phone calls, or respond to pages
- Physical threats
- Verbal outbursts
- Impatience with questions
- Refusal of assigned tasks
- Uncooperative attitudes during routine activities
- Use of condescending language

Frequent occurrences of these behaviors can significantly affect professional relationships and contribute to a hostile work environment.

Incivility

Incivility involves rude, inconsiderate, and generally disrespectful behavior. Examples of uncivil behavior in everyday scenarios include a teenager not giving up their bus seat for an older person, a co-worker interrupting someone mid-sentence, or a friend consistently arriving late to events. In the workplace, typical examples of incivility include:

- Condescending body language
- Texting or talking during someone else's presentation
- Mocking a colleague
- Jamming the copier and leaving it for others to fix
- Engaging in gossip
- Treating someone in a patronizing manner

Although these actions may seem minor, these behaviors can gradually erode workplace morale and mutual respect.

Bullying Behavior

Bullying represents a more serious type of negative behavior characterized by repeated patterns of destructive actions with the purpose of causing harm, whether intentional or not.

In the workplace, examples of incivility include condescending body language, texting or talking during someone else's presentation, mocking a colleague, jamming the copier and leaving it for others to fix, gossiping, or treating someone patronizingly.

Bullying is differentiated from incivility by the presence of three key elements:

- It targets a specific individual.
- There is intent to cause harm.
- The harmful behaviors are repeated.

For a behavior to be classified as bullying, these elements must consistently be present, distinguishing it from isolated incidents of incivility or disruptive behaviors. This persistence makes bullying particularly harmful in any environment.

Significance of Understanding These Behaviors

It is essential for case managers to accurately identify and differentiate between bullying, incivility, and disruptive behavior. Labeling all negative behaviors as bullying can diminish the gravity of genuine bullying incidents and hinder effective intervention strategies. To determine whether an incident qualifies as bullying, healthcare professionals should consider the following questions:

- Does the individual frequently exhibit this behavior?
- Is it explicitly directed at specific individuals (e.g., you and not others)?
- Is there an underlying intent to cause harm, whether conscious or unconscious?

If all three questions receive affirmative answers, it may indicate bullying. Otherwise, the behavior might be considered rudeness or poor manners that require correction.

Whether a behavior is classified as bullying, incivility, or a temporary lapse, promptly address it. These behaviors can damage workplace relationships and the overall work environment. By actively addressing and eliminating disruptive, uncivil, and bullying behaviors, healthcare professionals can cultivate a more respectful and productive workplace, improving patient care and staff well-being.

Strategies to Confront Disruptive Behaviors

Disruptive behaviors have been a persistent issue in healthcare for over a century, presenting significant challenges to delivering high-quality care and maintaining positive workplace environments. Without proactive intervention, these behaviors worsen, further complicating interactions among healthcare teams and the patient-caregiver relationship. Confronting such behaviors, especially when they involve overt aggression from colleagues, patients, or family members, can understandably evoke anxiety. However, evidence-based strategies exist to manage and reduce these incidents effectively. These strategies include establishing clear communication protocols, employing conflict resolution techniques, and promoting a culture of mutual respect and accountability within healthcare settings. By implementing these strategies, healthcare professionals can foster a more professional and respectful environment, ultimately improving patient care and enhancing collaboration among team members.

Confront: Name Behaviors

Identifying and explicitly naming behaviors is a highly effective strategy for addressing incivility in healthcare environments. When faced with overtly uncivil behavior, directly labeling the conduct in real-time can immediately interrupt the perpetrator and prevent further escalation. Individuals who engage in uncivil acts often derive a sense of power from aggressive outbursts, escalating as they shout or berate others. Interrupting this behavior by explicitly naming it can act like a defibrillator, disrupting the verbal assault.

Similarly, acknowledging awareness of covert incivility—such as eye-rolling or subtle undermining attempts—can unmask these behaviors. Individuals engaging in covert actions often believe they go unnoticed until explicitly confronted. Once their actions are named, they typically cease their behavior.

For this approach to be practical, it must address specific observable behaviors, such as,

- "This is the third time you've interrupted me as I was speaking."
- "You are raising your voice at me in front of others."
- "I noticed you rolling your eyes. Just say no."

Naming behavior leverages assertive communication skills, emphasizing direct and honest interaction. It not only adheres to principles of assertive communication but explicitly recognizes and addresses unprofessional conduct. By naming behaviors, individuals can effectively confront and highlight inappropriate actions, fostering a culture of respect and professionalism in the workplace. This technique is particularly valuable in the healthcare workplace where mutual respect is crucial, ensuring all parties understand the impact

of their behavior and promoting transparency and constructive feedback.

Communicate Assertively

Case managers, who may not always be fully integrated into interprofessional teams, tend to adopt a passive communication approach in many situations. An illustrative example of this occurred when I witnessed a case manager who was specifically excluded from patient care rounds led by physician residents. During these rounds, a trauma physician would conduct bedside rounds followed by hallway debriefings with residents and interns. The physician positioned himself against the wall, forming a semi-circle with his interns, effectively excluding the case manager standing outside the group without interjecting. Later that morning, she expressed her frustration about being excluded.

Individuals who adopt a passive communication style often prioritize politeness and may hesitate to express their true feelings to avoid conflict or offending others. However, this passive approach can make them vulnerable to bullying and incivility, as their reluctance to speak up may be perceived as a weakness.

Case managers must adopt an assertive communication style to earn recognition as valuable members of interprofessional teams. Practicing assertive communication involves:

- Addressing concerns directly with the relevant individual rather than discussing them indirectly.
- Engaging actively in listening and reflecting on other's viewpoints.
- Maintaining direct eye contact during conversations.
- Demonstrating self-awareness and maintaining a relaxed posture.
- Communicating positively and constructively, avoiding judgmental and labeling language.

Assertive case managers can assert their role effectively within interprofessional teams, fostering respect and collaboration while minimizing misunderstandings and conflicts.

Strategies for Enhancing Assertive Communication

1. Pause Before Speaking

Taking a moment before speaking is a critical first step. Pausing allows for a thoughtful and considerate response. Before speaking, consider:

- What are the objectives?
- What are my alternatives?
- How can I communicate in a way that is both honest and respectful?

2. Observe Nonverbal Cues

Nonverbal communication can often convey messages more powerful than spoken words:

- **Establish Equality:** Reflect on your counterpart's posture. If a co-worker sits, consider sitting as well. If they stand, you might stand, too. This mirroring promotes assertive communication by creating a sense of equality.
- **Maintain an Open and Confident Posture:** Avoid defensive postures such as crossing your arms. Keep a balanced stance with feet slightly apart, arms open, and palms facing upward. Avoid clenched fists or a rigid posture and maintain steady eye contact.
- **Modulate Your Tone:** Speaking too quickly, with a high-pitched voice, or in a whisper can signal nervousness or lack of confidence. Instead, take deep breaths, speak clearly and audibly, and avoid rushing your words.

3. Use Scripting

- Incorporating scripts into your communication can enhance clarity and assertiveness. Here are examples and their practical application. "I'm concerned about…" This phrase effectively expresses worries or issues without sounding accusatory. It opens the door for constructive conversation. For instance:
  —"I'm concerned about the decision to discharge the patient tomorrow. I'm not sure you're aware that she lives alone, and her only bathroom is on the second floor of her house."
- "Help me to understand…" This script helps seek clarification and promote a collaborative discussion. It encourages the other person to share their perspective and fosters mutual understanding. For example:
  —"Help me understand the rationale behind the new policy implementation." This phrase is diplomatic for addressing potential oversights or misunderstandings and tactfully addressing issues.
  —For instance, "I'm not sure you are aware, but the recent feedback from the patient's family indicates some dissatisfaction with our current approach."

These scripted phrases provide structured and respectful approaches to initiate difficult conversations, helping to maintain professionalism and keeping the focus on resolving issues.

Use Scripted Language

When confronted with unexpected disrespectful behavior, individuals often feel unsure how to react. This uncertainty may manifest as freezing, retaliating, or withdrawing from the situation. These reactions stem from "the "fight or flight" response, in which the adrenal glands release adrenaline and cortisol. Initially, these stress hormones affect the amygdala, known as the brain's emotional center, triggering impulsive reactions that may not be professional. There's a delay before these hormones reach the prefrontal cortex, which is responsible for rational thinking and decision-making. This area is

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Nail Technicians as Community Health Workers: Amplifying Case Management Success

By Shawna Wilson, BSN, RN

Nail Technicians as Community Health Workers (CHW)

In the ongoing pursuit of improving patient outcomes while reducing costs, the utilization of community health workers (CHWs) and lay health workers (LHWs) has proven beneficial (Lewin et al. 2010) "Community health workers are lay members of the community who work either for pay or as volunteers in association with the local health care system in both urban and rural environments" (NIH 2020). "CHWs offer interpretation and translation services, provide culturally appropriate health education and information, help people get the care they need, give informal counseling and guidance on health behavior." Many states now offer formal training programs and certifications for CHWs, although certification is not usually required (NASHP 2025).

Although CHWs and LHWs can be engaged at a lower cost than most medical professionals, they achieve higher levels of engagement (Knowles et al. 2023) and improve patient experiences. CHWs and LHWs frequently live in the communities they serve and share language, ethnicity, socioeconomic status, and life experiences with their clients. These shared experiences can open the door to developing trust in relationships. In a study exploring hair stylists as LHWs, Palmer and colleagues found that trust was a significant factor for engagement, and clients who trusted their stylist were also receptive to their guidance in other areas of their lives. They also found a higher occurrence of inherent trust when individuals shared racial congruence (2023).

BelleCare has incorporated licensed nail technicians as paid CHWs in its integrated care model. The company is a privately owned start-up that partners with Medicare Advantage Health Plans to provide high-risk members with an in-home, preventive foot service completed by these licensed nail technicians. Along with the preventive foot service, the technicians document their observations about the feet and lower legs, gather medical history data, and note any social determinants of health issues observed or reported during the visit. A registered nurse on the Belle team reviews this information, and a case manager (CM) addresses any concerns for quick intervention and resolution at no additional cost to members or payer partners.

Belle employs technicians in Florida, Kansas, Missouri, and Georgia. Currently, the technicians are not certified CHWs, but Belle was recently approved as a Florida CHW Approved Educator. The company plans to pursue the same accreditation in all states where they operate and make CHW certification a requirement for their technicians.

Belle Background

In 2014, Belle started as a concierge beauty service offering manicures, pedicures, hair styling, massage, and more in clients' homes. By 2016, it became clear that there was a significant need for foot care for seniors with chronic health issues. Belle then changed its business model, and in 2019, it partnered with its first Medicare Advantage payer to offer in-home preventive pedicure services as a benefit to members with a higher risk for foot complications, particularly those with chronic medical conditions such as diabetes, neuropathy, peripheral vascular disease, and kidney disease.

Belle's preventive foot service, subsequent nurse review, and CM interventions help promote member health and reduce health plan costs. According to large-scale retrospective analysis and causal analysis studies completed with three major health plans (Lewin et al. 2010), Belle saw statistically significant reductions in emergency room, inpatient, and skilled facility use, falls, open wounds, and diabetes-related complications (Figures 1 and 2).

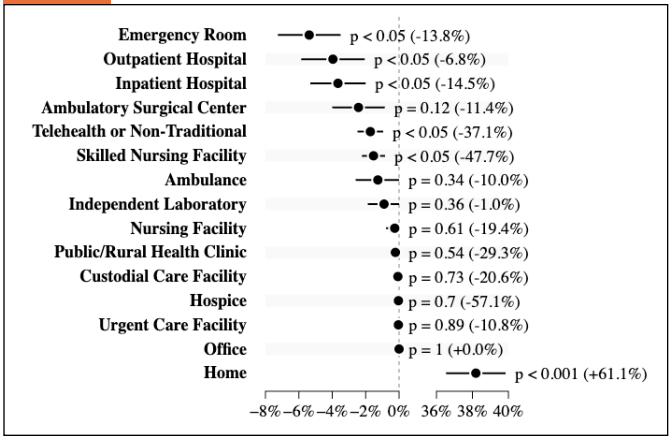
Belle estimates an average reduction of $1,320 in the total cost of care per member per year, for new members identified to be at elevated risk (Figure 3). Belle's model also reduces disenrollment and drives broader healthcare engagement.

The "Belle Service"—More Than a Pedicure

The Belle technicians provide a podiatrist-reviewed pedicure service that complies with the American Diabetes

Shawna Wilson *is the Director of Case Management at Belle. Opinions expressed within the content are solely the author's and do not reflect the views and beliefs of BelleCare or its affiliates.*

FIGURE 1 RESULTS OF LARGE-SCALE ANALYSIS STUDIES



Source: *Goldberg, Eli. "Belle's Therapeutic-as-a-Service (TaaS) Preventative Model on Par with Blockbuster Drugs". Belle Cares, Innovation and Data Science (2024).*

FIGURE 2 PACES CLINICAL EPISODE GROUPER

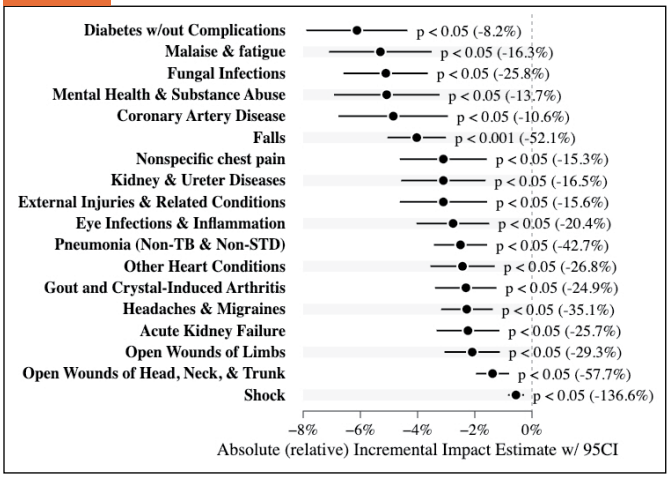
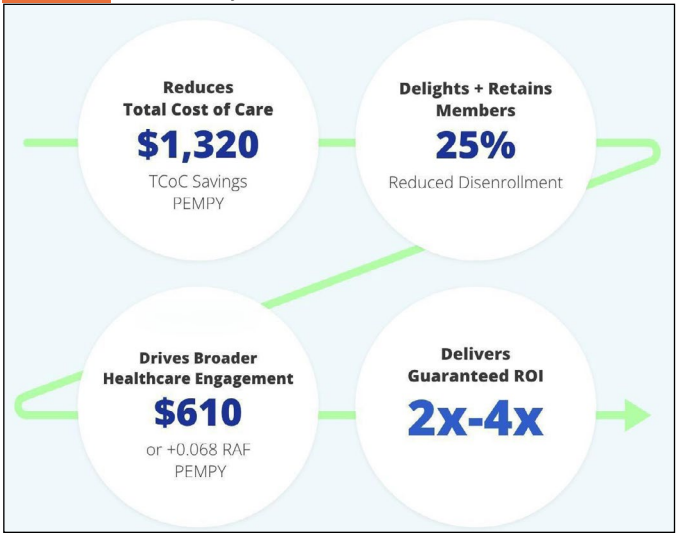


FIGURE 3 REDUCED COSTS, LOWER DISENROLLMENT NUMBERS, AND BROADER ENGAGEMENT



Association's standards. However, its value extends beyond providing preventive pedicures. These technicians are the eyes and ears of Belle's case management team. They are trained to detect emerging health issues in the feet and lower legs, such as skin breakdown and signs and symptoms of infection. Technicians are also trained to perform simple screening tests for sensation and circulation and to gather medical history data points related to diabetes, neuropathy, cardiovascular events, and past foot ulcerations.

The service is provided in the comfort of the member's home, which helps members feel at ease and sets the stage for the technician to establish a caring and trusting relationship. Conducting the service in the home also gives the technician insight into the member's living environment and social circumstances, a rare opportunity for healthcare workers. The trusting relationship the technician develops with the member paves the way for Belle's CMs to offer additional support such as education, connect members with appropriate care, and access health plan benefits and community resources.

Case Study 1

The following case study highlights the value of the technician-to-member relationship. A technician visited a 90-year-old female managed care member whose spouse had recently passed away. The member had been reliant on her spouse for assistance. During their conversation, the member shared that she had not showered for several weeks because she was afraid of falling without anyone to assist her. The member also shared that she had no family nearby to help her and asked the technician if she knew anyone who could help with household chores. The member felt comfortable enough to share her personal needs with the technician. As a result, CMs were able to provide resources to assist her with showering and housekeeping. Given that the member lived alone and did not have family nearby, her needs may not have been noticed, adversely affecting her health.

Arming Technicians

Belle technicians must work within the parameters of a nail technician license in their state. They must also complete Belle's comprehensive training program. The training begins with a week-long program that includes classroom instruction, hands-on practice, and shadowing experiences with seasoned technicians.

The classroom instruction covers foot care service steps, communication skills, common foot ailments, personal safety, documentation best practices, chronic conditions, social determinants of health, and the procedures to follow in emergent/urgent situations. The technicians are also instructed to remain within the scope of their professional licenses by avoiding areas of compromised skin and relying on the nurse CMs to reach out to members if further care is needed.

"I have a report with photos on how a member is doing within minutes of the appointment completion. There is no delay in charting. A nurse reviews every appointment, and then a second nurse CM reviews it when the member is flagged for a possible issue."

After completing the week-long intensive training, technicians undergo 6 weeks of educational modules, followed by continuing education every 2 months. This specialized and intensive training empowers technicians to contribute to the overall health and well-being of the members.

Belle technicians must also adhere to an internal policy that defines the requirements for employment (e.g., state nail technician licensure, background checks), expectations, and initial and ongoing education requirements. The policy also specifies the conditions and expected standards for remaining in the role and outlines the disciplinary measures if the conditions are not met.

Belle provides its technicians with a mobile, clinician-designed application that guides them through the steps of a member visit and documentation process. The app directs the technicians to take before and after photos, document observations, and answer clinical, behavioral, and social determinants of health questions. The app also contains educational prompts for technicians, assisting them in asking assessment questions and providing simple member education, such as the importance of wearing socks and shoes and inspecting their feet daily.

While the app is designed to cover the most anticipated observations that may be encountered, the technicians also have a note section where they can provide additional information to the nurse reviewer.

Belle technicians can also connect with Belle CMs directly, if needed. If a technician has concerns during the member visit, they can reach the CMs via telephone or video chat.

Belle Case Management

Belle employs experienced registered nurses to provide case management services. The CMs follow specific workflow guidelines, which include expected interventions, triage forms, follow-up expectations, and criteria for closing cases. CMs are required to adhere to internal policies for handling cases involving possible suicidal ideation, abuse, and neglect. When CMs face challenging cases, they are encouraged to discuss them in a weekly case conference meeting with the rest of the case management team. Belle's Director of Clinical Operations conducts a monthly quality check for each CM by reviewing a sample of cases and member phone calls, followed by a one-on-one meeting to discuss areas for improvement.

The clinical data and observations collected by the technicians during the service guide CMs' efforts. They transmit appointment documentation instantly through a secure proprietary platform. Once they receive documentation, a registered nurse reviews it to identify any issues that may benefit from case management assistance. Specifically, they are looking for medical problems not currently being addressed and social determinants of health causing barriers to care or contributing to declining health status.

Belle began using nurses to review appointment documentation in 2019. The nurses check the documentation for each appointment, reach out to members with untreated foot problems, and refer them for necessary care. As Belle has expanded, their case management services have grown to cover other issues. The assessment guiding the technicians today collects a wealth of information about non-foot health issues such as acute illnesses, worsening chronic conditions, challenges in accessing proper care, and social determinants of health that could benefit from the support of CMs.

As technicians address a wider range of issues, the CMs' level of intervention has also expanded. Today, the CMs review the flagged issues and directly contact the patients. They triage the problems and others that may arise during patient conversations. They aim to follow problems from recognition to resolution, assisting, as needed, every step of the way. They coordinate care, provide education, connect members with resources to overcome care barriers, and help facilitate communication between members' care teams. Currently, over 13% of Belle's members receive CM intervention at least once a year. Additionally, Belle CMs often intervene when members aren't receiving active case management from other sources, facilitating referrals, communicating with providers and payer case management teams, acting as intermediaries for members and their care teams, and working to help members overcome barriers to care. Through these actions, Belle CMs bridge gaps within the integrated care model.

Belle's CMs work together with the case management teams of their payer partners. They notify and update them on member issues and enlist their assistance for social work services to access plan benefits. Belle also facilitates direct connections between members and their payer CMs to address member issues and close gaps in care. Their payer partners appreciate the extra care and attention their

"They [technicians] discover things that we may not have ever known, and the relationship they build with the members allows the members to trust and confide in them. This helps the CMs begin to create a relationship with the members.

members receive from Belle's case management services.

Just as the technicians can connect with CMs, CMs can arrange a video chat with the technician during the member's visit, which can help facilitate contact with the member, aid assessment, and encourage engagement. These point-of-service interactions between the member, technicians, and CMs support joint decision-making, enhance member satisfaction, and assist with care coordination.

Case Study 2

The following case study highlights the value of the technician's link between the member and the CM. A technician arrived at the home of her 75-year-old female member. The member did not answer the door but responded weakly with "Yes?" when the technician knocked. This technician had visited the member many times before and knew she lived alone. Concerned about the member, the technician called the CM for assistance. The CM couldn't reach the member by phone, and there was no emergency contact on file for the member. The CM contacted the local sheriff's department and requested a well-check. The sheriff entered the member's home and found her unconscious and hypoglycemic. EMS arrived, stabilized the member's blood sugar, and transported her to the hospital. The technician followed her training and enlisted the expertise of the CM to get this member the emergent help she needed.

Technicians Are the Cornerstone

Belle's case management success relies on its technicians. The clinical data and insights they provide and the trusting relationships they build, form the basis for effective case management intervention. As a result, effective case management intervention leads to improved member outcomes and savings for payer partners.

It's crucial for the data collected during home visits to be accurate, which depends on the technician's commitment, integrity, and knowledge. To proactively address commitment and integrity, Belle has found it crucial to keep a constant and evolving focus on quality recruitment and management through screening, credentialing, and performance management practices. Belle is dedicated to providing opportunities for technicians to gain and continuously improve their knowledge and skills through high-quality onboarding, ongoing education, and quality assurance checks in both controlled and field settings.

A Belle CM had this to say about the technicians: "They discover things that we may not have ever known, and the relationship they build with the members allows the members to trust and confide in them. This helps the CMs begin to create a relationship with the members. Although not medically licensed, they are trained to recognize any health or medical issues and social determinants of health. I feel they do an amazing job collecting as much data as possible, which allows the CMs to assist the members with what is needed."

With technicians gathering accurate data and building relationships, and specialized review nurses zeroing in on issues, the CMs can focus solely on providing meaningful interventions to meet the members' needs. This allows CMs to use their clinical knowledge and communication skills to promote member health and work at the top of their licenses.

Case Study 3

An 82-year-old member with macular degeneration blindness had a fall before the technician visited. The Belle CM contacted the member and learned the member had been evaluated by her PCP after the fall. Through continued conversation with the member, the CM learned that the member was having difficulty completing household chores and lacked adequate transportation. The CM also believed the member would benefit from fall prevention assistance, including physical therapy for strengthening and a fall safety button. The Belle CM connected the member to the payer CM team, resulting in the member receiving a part-time caregiver and physical therapy through home health. The Belle CM also connected the member to a community agency that provided transportation services and assisted her with a Medicaid application for more resources. The Belle CM not only made referrals but also helped the member connect with resources directly over the phone, a task that the member found immensely challenging due to her visual impairment. The member expressed, "I can't tell you how much I appreciate being able to call on you as a resource, because I was not getting anywhere."

Looking forward

Belle uses technology in their mobile application to guide technician service and a proprietary platform to streamline nurse review of documentation and case management interventions. They believe that the future of healthcare involves combining

continues on page 24

CE3 Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on October 17, 2025

Enhancing Liver Transplant Success: The Crucial Role of Case Management in Patient Care, Part 2

By Janet Coulter, MSN, MS, RN, CCM, FCM; Anila Momin, MSN, MBA, RN; Lauren Thomas, MSN, RN, CCM; and Amanda Ward, BSN, RN

Introduction

In the February/March issue of *CareManagement*, we published Part I of "Enhancing Liver Transplant Success." In this issue, we continue with Part 2, which focuses on transplant operative procedures, potential complications, and the role of case managers in promoting success of the transported organ and health of the patient. As of September 2024, 9,924 individuals in the US were awaiting a liver transplant, according to the Organ Procurement and Transplantation Network (OPTN) (OPTN, 2024). In 2023, the United Network for Organ Sharing (UNOS) reported a record-breaking 10,660 liver transplants, the highest number ever performed in a single year (Terrault, N. A., et al., 2023). This growing number of liver transplants underscores the increasing need for comprehensive case management.

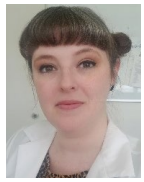
Transplant Operative Procedure

Once a suitable donor has been identified, the designated transplant candidate is notified, and the risks and benefits of the procedure are discussed again. If the patient consents, the surgery is scheduled. Organ preservation is the method of keeping organs viable while out of the human body. Without this, organ donation and transplantation would not be possible. During the warm ischemic phase, the donor's circulation ceases, and the organ receives an infusion of cold preservatives (Finger, 2023). The solutions to preserve organs are designed to decrease injury and maintain graft function (Finger, 2023). Injury can also occur when the organ is re-perfused with the recipient's blood (Finger, 2023). Recent techniques to decrease injury and improve function include normothermic perfusion machines that restore blood flow

Janet S. Coulter, MSN, MS, RN, CCM, FCM, *is a Fellow of Case Management and a board-certified transplant case manager. For the past 3 years she has been providing case management services for solid organ and blood and marrow transplant patients. She is currently President of the Case Management Society of America National Board of Directors. She has held positions as a nurse educator, administrator, team leader, and Director of Case Management. Janet holds a Master of Science in Nursing from West Virginia University and a Master of Science in Adult Education from Marshall University. Janet has been a recipient of the CMSA National Award of Service Excellence and Southern Ohio Valley CMSA Case Management Leadership award.*

Anila Momin, MSN, MBA, RN*, is a transplant case manager. For the past 6 years she has been working for a large insurance company providing and coordinating care for solid organ and blood and marrow transplant. Her prior 18 years of nursing experience includes adult critical care, telemetry, medical surgical, emergency department, and LTAC nursing. Anila holds a dual Master of Science in Nursing and Master's in Business Administration with focus in healthcare administration.*

Lauren Thomas, MSN, RN, CCM*, has spent her entire nursing career caring for transplant patients. After graduating with a degree in English and Creative Writing, she earned a BS in Nursing. She began her career caring for pre- and post-kidney and liver transplant patients as well as general medicine and surgery patients in New York City. She then moved to Georgia, where she worked in a pediatric cardiac intensive care unit. After earning her Master's in Nursing Education, she became a heart transplant coordinator, educating and working with pre- and post-heart transplant patients throughout the evaluation, listing, surgical, and post-transplant process. She previously earned her CCRN and CCTC certifications. For the past 3 years, she has been a transplant case manager.*



Amanda Ward BSN, RN, *is a transplant nurse case manager. Amanda specialized in hepatology and liver transplant for over 8 years as a transplant coordinator in Texas and Washington state. For the past 4 years she has been working as a nurse case manager specializing in solid organ and blood and marrow transplants, working with patients across the nation to provide support, education, and interdisciplinary coordination to improve outcomes for each patient.*

Recent techniques to decrease injury and improve function include normothermic perfusion machines that restore blood flow as opposed to sub-normothermic preservation, hypothermic preservation, high sub-zero preservation, which reduce metabolism, and cryopreservation (Finger, 2023).

as opposed to sub-normothermic preservation, hypothermic preservation, high sub-zero preservation, which reduce metabolism, and cryopreservation (Finger, 2023). Normothermic machine perfusion is also known as "liver in a box," in which the organ has blood pumping through it just outside of the body (Mayo Clinic, 2024, June 3). Fortunately, livers can be preserved out of the body for up to 12 to 18 hours, allowing time for harvesting and transporting organs (Hertl, 2022).

The transplant is done in the operating room under general anesthesia. Over the past few decades, the use of venovenous bypass has decreased due to the need for heparin. Some centers still use it to maintain hemodynamic stability (Butt et al., 2024). Central line access is necessary to administer various medications, fluids, and blood products and to monitor volume status. An arterial line provides constant blood pressure monitoring. Almost uniformly, induction immunosuppression is given with medications such as basiliximab or thymoglobulin. The original liver is removed and sent for pathology. The bile ducts, hepatic arteries, and portal veins are connected from the donor liver to the recipient anatomy. A nasogastric tube is placed to empty air and stomach contents, and a Foley catheter drains and measures urine. A T-tube, named for the shape of where it is inserted, directs and drains bile while the anastomosis site heals. Jackson-Pratt drains are placed in the abdominal cavity to suction off excess fluid. The surgical incision transverses the abdominal cavity horizontally as well as caudally in an upside-down Y shape, often known as a Mercedes or Chevron incision. Recent research into a smaller J-shaped incision has shown decreased complication rates (Heisterkamp, et al., 2008). The wound is closed with staples, stitches, or glue. The surgery tends to take between 4 and 12 hours. Afterward, the patient is transferred to an intensive care unit.

Types of Liver Transplants

Most transplanted livers continue to come from deceased, brain-dead donors. These organs are viable because while the donor is brain dead, their heart continues to beat and circulate blood to other vital organs such as the liver. This keeps the donor's liver healthy. In children under 2 years old, whose immune systems are not fully developed, ABO-incompatible transplants are possible, an amazing immunological opportunity to widen the donor pool in these patients, for whom finding an appropriately sized organ can be challenging (Hertl, 2022).

More recently, donors after cardiac death (DCD) have become potential donors. These patients do not meet the strict criteria for brain death and are declared dead once their heart stops (UCSF, n.d.). With the stopping of the heart comes the immediate start of cell death throughout the body, including the liver, so organ harvesting is done as quickly as possible (UCSF, n.d.). However, a high risk of bile duct complications, hepatic artery thrombosis, and organ failure due to ischemia have limited this practice (Hertl, 2022; UCSF, n.d.).

Partial, or split livers, can come either from a living donor who gives a part of their liver or a deceased donor whose liver is divided into 2 parts, the more extensive right lobe section for an adult and the smaller left lobe for a child (Cleveland Clinic, 2024, May 1). The liver comprises 8 segments, 4 on each side, with the right side accounting for about 60% of transplants (UCSF, n.d.). The partial liver will regrow to full size within a few months (Mayo Clinic, 2024, January 19). Living donors are usually reserved for stable patients deemed not to require a whole liver or for parents of children needing a liver transplant. Unfortunately, living donors have a mortality risk of 1 in 600 to 700 (Hertl, 2022). However, living-donor recipients survive longer (Mayo Clinic, 2024, January 19). Another benefit is that the surgery can be scheduled to accommodate the donor, recipient, and surgical team and allow the medical team to optimize the recipient's medical status.

Finally, liver-paired donation is an option. When a person has a potential living donor who does not match due to blood type, antibody, size, or vessel incompatibility, the donor could donate their partial liver to a stranger. At the same time, the recipient receives the stranger's partial organ (UNOS, n.d.).

Postoperative Care

Postoperatively, emphasis focuses on hemodynamical stability, weaning off the ventilator, and early ambulation. The sooner patients breathe independently and are out of bed, the lower the risk of blood clots, pneumonia, other infections, and deconditioning. Many of these patients have collected excess fluid for months or years, so diuresis continues. Amazingly, the goal length of stay for liver transplant is now just 7 days,

Hyperacute rejection is usually the result of an HLA antibody mismatch; given the enhanced testing pretransplant, this type of rejection is nowadays very uncommon.

according to Milliman Guidelines (MCG Health, 2024). Pediatric patients and those who were hospitalized or very ill before transplant tend to have longer inpatient stays.

Patients are started on immunosuppression immediately after surgery, first by nasogastric tube or intravenously, and then transitioned to oral when appropriate. The usual immunosuppressant regimen combines tacrolimus, mycophenolate, and prednisone. Tacrolimus, or a similar calcineurin inhibitor, blocks a pathway that produces cytokines, substances that cause the immune system to respond (UCSF, n.d.). Meanwhile, mycophenolate blocks lymphocytes, a type of white blood cell from replicating (UCSF, n.d.). Steroids such as prednisone also reduce inflammation and cytokine production (UCSF, n.d.).

The nurse checks the patient's liver enzymes daily to monitor for rejection. These levels, which often spike severely initially right after transplant, should improve daily. In addition, the recipient's kidney function, electrolytes, and coagulation factors are monitored. These, too, should steadily improve if the new liver is working well. Tylenol and short-term narcotics are often utilized for pain control. NSAIDs are avoided in transplant patients to prevent further strain on the kidneys. Interestingly, many liver recipients report minimal pain, possibly due to the masking effect of their steroids. Once the patient stabilizes, usually after 2-4 days, they may be transferred to a regular floor room. At this point, discharge teaching regarding the recipients' new medications and life with a transplant should be started.

While case management interventions should begin as soon as possible after transplant, case management assistance is vital in the days before discharge for discharge planning and network steerage. Many post-transplant patients require home care post discharge. These services include skilled nursing care for wound management, line management, and labs if sent home with a central line, medication education and management, physical therapy, occupational therapy, and durable medication equipment. A transplant case manager can ensure that the home or outpatient services are a covered benefit, that the member utilizes in-network providers, and that services are pre-authorized or reviewed for medical necessity if required. This assistance prevents delays in care, prolonged inpatient admission, and unnecessary expenses for the patient and family.

In addition, case managers may facilitate network steerage and preauthorization to inpatient facilities such as acute or subacute rehabilitation. Of note, many transplant programs try to avoid sending fresh transplant patients to inpatient centers due to the risk of infections and lack of specialized transplant care.

Post-Transplant Complications

As with all transplants, liver transplant comes with many potential postoperative complications, including the risk of both rejection and infection. Other short-term complications include bleeding, clotting, primary graft dysfunction, and biliary issues. Post surgical patients may experience electrolyte imbalances due to fluid shifts, medications, and the stress of surgery. Long-term complications occur after liver transplant as well. These include a risk of cancers, recurrent infections, and side effects of immunosuppressant medications, such as kidney failure. Biliary strictures also frequently occur many years post-transplant (Hertl, 2022).

Rejection

The risk of rejection is highest in the first 3 months after a liver transplant. In rejection, the patient's immune system identifies the transplanted liver as foreign and attacks it. Rejection can be hyperacute, acute, or chronic. Hyperacute rejection is usually the result of an HLA antibody mismatch; given the enhanced testing pretransplant, this type of rejection is nowadays very uncommon. Acute rejection, however, occurs in 25-50% of liver transplant patients within the first year posttransplant, with most episodes within the first few months' post-transplant (UCSF, n.d.). Those at higher risk for rejection include younger recipients (presumably due to their stronger immune system), older donors, HLA mismatches, longer ischemia times, and those with autoimmune disorders (Hertl, 2022). Fortunately, in most episodes of acute rejection, organ function is preserved. Treatment includes increased immunosuppression doses and steroid bursts. Chronic rejection, though less common, can eventually lead to graft failure, which occurs most frequently when a patient has had repeated rejections.

Some patients will experience jaundice, fatigue, malaise, and abdominal swelling while experiencing rejection. However, some patients will have no symptoms. For this reason, regular post-transplant visits with the transplant team and routine lab monitoring (liver enzymes, bilirubin

TABLE 1 COMPLICATIONS AFTER A LIVER TRANSPLANT

- Primary graft nonfunction
- Hepatic artery Stenosis and thrombosis
- Hepatic outflow obstruction
- Bleeding
- Ascites and fluid retention
- Infection
- Organ rejection
- Neurologic complications
- Malignancy disease recurrence
- Electrolyte imbalances and other metabolic abnormalities
- Renal dysfunction
- Incisional hernia
- Portal vein stenosis and thrombus (rare)

Reference: https://my.clevelandclinic.org/department *Post-Liver Transplantation Management Cleveland Clinic Foundation*

levels, immunosuppressant levels, and blood counts) are essential. If rejection is suspected, a liver biopsy can be done for confirmation.

Infection

Infection is the leading cause of morbidity and mortality post-transplant. Given the need for immunosuppressant medication to prevent rejection, all transplant patients are at higher risk of infections, including bacterial, viral, and fungal infections. During the first month, infections are often linked to the surgery itself and exposure to hospital-acquired organisms. The transplant incision is a potential source of infection, so meticulous wound care is essential, as well as frequent monitoring for wound infection, such as redness, swelling, increased pain, and drainage from the wound site. Beyond six months, common infections include influenza, urinary tract infections, fungal infections, herpes zoster, and pneumonia. Interestingly, transplant patients, due to their compromised immune system, often suffer from "atypical" or unusual infections that are rarely seen in other patients whose immune systems can fight them off. Oftentimes, transplant teams work closely with their institutions Infectious Disease team to diagnose, support, and manage these atypical infections.

Bleeding

Given that one of the livers many purposes is to make clotting factors, liver failure patients are often coagulopathic before surgery. The use of heparin further heightens the risk of bleeding. It is common for liver transplant surgeries to include multiple units of packed red blood cells, platelets, fresh frozen plasma, and clotting factors. Partial or split livers are at particular risk of increased bleeding due to the cut edge of the liver.

Clotting

Conversely, clotting can occur due to prolonged bed rest and the administration of clotting factors. Hepatic artery thrombosis occurs in 2-5% of deceased donor liver transplants and is even more common with living donors (UCSF, n.d.). Less common is clotting of the portal vein.

Primary graft dysfunction

Primary or delayed graft function occurs when the transplanted organ does not function despite blood flow restoration. Graft nonfunction can result from complications like hepatic artery or portal vein stenosis or thrombosis. Graft nonfunction is more likely to occur when the organ has been out of the body longer.

Biliary complications

Biliary stenosis is the most common technical complication of liver transplant surgery. Biliary issues include leaks, scarring, and narrowing of the bile ducts (UCSF, n.d.). Unfortunately, the University of California San Francisco quotes a biliary complication risk of 15% in deceased donor transplants and 40% of liver transplants (UCSF, n.d.).

Recurrent ascites

Ascites, or excess abdominal fluid that is present in most pre-liver transplant patients, can continue to occur in up to 7% of post-liver transplant patients; more than just an annoyance, it is associated with lower survival rates (Ostojic et al., 2022). Causes include vascular obstructions, heart or kidney failure, Hepatitis C recurrence, and rejection (Ostojic et al., 2022). Treatment includes giving diuretics, draining fluid, determining albumin levels, and treating the underlying cause. Occasionally, TIPS therapy can be utilized (Ostojic et al., 2022).

Cancer

Transplant patients have a higher risk of all cancers. The most common cancers in post-liver transplant patients are skin cancer and lymphoma (Professional, 2024). Another type of cancer specific to transplant patients is known as post-transplant lymphoproliferative disorder (PTLD). This disease occurs in patients who have been exposed to the Epstein-Barr Virus.

Recurrent infections

Hepatitis B or C, if present before transplant, can reoccur; both are now easily managed or cured by medication (Hertl, 2022). Other diseases that caused the liver to fail initially,

especially those with an autoimmune component, such as primary sclerosing cholangitis and primary biliary cirrhosis, have been known to reoccur (Hertl, 2022; UCSF n.d.).

Medication side effects

The immunosuppressants used to prevent organ rejection all carry risks. Tacrolimus, also known as Prograf or Envarsus, causes high blood pressure, elevated blood glucose, renal dysfunction, confusion, tremors, and headaches; levels must be closely monitored, as the drug has a very narrow therapeutic window. Mycophenolate, known as Cellcept or Myfortic, is infamous for causing gastrointestinal issues. Long-term use of prednisone, a steroid, can cause elevated blood sugars or diabetes, weight gain, swelling, and weak bones; for this reason, most transplant centers attempt to wean patients off this medication within 6-12 months.

Kidney insufficiency

Hepatorenal syndrome, transplant surgery, and post-transplant immunosuppressants all place a significant strain on the kidneys.

Hyperlipidemia

Up to 69% of patients suffer from hyperlipidemia; many patients are prophylactically placed on antihypertensive agents (Halliday & Westbrook, 2017).

Case Management Interventions

The first 3 to 6 months following liver transplantation are the most challenging, both physically and emotionally. Recovery can take several months, involving numerous medical appointments, laboratory tests, and potential complications. Typically, physician appointments and lab studies are scheduled biweekly for the first 2 weeks, weekly for the next 8 weeks, biweekly for the following 2 months, and then monthly once the patient is stable.

The case manager plays a crucial role in the recovery of the liver transplant patient both preoperatively and post-transplant. Assistance provided by case managers includes emotional support, transplant education and medication teaching, infection monitoring, self-care, and financial and psychosocial resources. Case managers have the unique opportunity to provide care and education to patients and caregivers in the comfort of the member's home. Oftentimes, medical appointments are rushed and overwhelming, and critical information can be confusing or missed. By communicating with patients and families at a less stressful time, information provided is better understood and received. Many patients also enjoy having a case manager "check on them" and speaking with someone not directly in their medical team. Of course, case managers must be careful not to provide medical advice in conflict with or in place of the transplant team.

TABLE 2 THINGS TO AVOID POST-TRANSPLANT

- "Live" vaccines
- Close contact with anyone who has an infectious disease
- Alcohol, smoking, and recreational drugs
- Water from lakes or rivers
- Unpasteurized milk products and raw or undercooked eggs, meats, and seafood
- Walking barefoot outside
- Dirty diapers
- Gardening
- Animal feces
- Check new pets with the transplant team
- Whirlpool/hot tubs
- Pregnancy within the first-year post-transplant
- Any medications (either OTC or prescribed by non-transplant physicians) unless approved by the transplant team
- Strenuous exercise for the first 6 months

One role case managers serve is by being active listeners and offering encouragement and support. Liver transplant recipients often experience a range of emotions, including depression, survivors' guilt, and anxiety. They may feel overwhelmed by the life-changing nature of their transplant, coupled with the stress of being on the waiting list, waiting for "the call," undergoing surgery, hospitalization, managing medications, and being away from home.

Supporting both the patient and their caregivers is vital. The case manager should assess the strengths and weaknesses of the patients' support system and caregivers. Caregivers may need gentle reminders to take care of themselves, as caring for a liver transplant recipient in the immediate post-transplant period is both demanding and time-consuming.

Case managers should instruct the patient and caregiver on proper incision care, assess the effectiveness of pain management, ensure reliable transportation for appointments, promote a healthy, well-balanced diet, and encourage participation in physical and occupational therapy or rehabilitation. However, strenuous activities and heavy lifting should be avoided for at least 3 months post-transplant, as strength will gradually return. Restrict exercises that strain abdominal muscles in the first 6 months after the liver transplant. Education on recommended lifestyle changes

The case manager also guides patients through the post-transplant period by setting clear expectations for recovery that can help alleviate the patient's stress and unrealistic expectations.

is also essential, including recognizing and reporting signs of infection or organ rejection to the transplant team. Even seemingly innocuous issues, such as fevers, diarrhea, weight changes, and increased fatigue, should be reported. These symptoms, which may be insignificant in the general population, can be early indicators of rejection, infection, or malignancy in a transplant patient, and recipients must be encouraged to notify the transplant team of all changes.

The case manager also guides patients through the post-transplant period by setting clear expectations for recovery that can help alleviate the patient's stress and unrealistic expectations. Transplant recipients, who have often felt poorly for many years, creating a new and lower standard of living, do not always realize how ill they were pre-transplant and express frustration when their recovery is slower than they expect. Honest dialogue about potential complications post-transplant prepares the patient for the lifetime of care. Encouraging participation in support groups and connecting with others who have undergone a liver transplant can be particularly beneficial, as social support reduces rates of depression and noncompliance.

Liver transplant recipients will be on maintenance medications for the rest of their lives, including proton pump inhibitors, antihypertensives, insulin or oral hypoglycemic agents, mild analgesics, and most importantly, immunosuppressive medications. The case manager should provide education on medication administration, potential side effects, and the critical importance of adhering to the prescribed medication regimen. The case manager should emphasize the importance of contacting the transplant team with questions, concerns, new symptoms, or trouble obtaining their medications. It may be helpful for transplant patients to wear a medical bracelet or necklace to alert emergency personnel that they have had a transplant and are taking immunosuppressive medications.

Many transplant patients face financial concerns postoperatively due to the cost of medical bills and medications and their potential loss of income while ill. Case managers can provide various national, local, and disease-specific resources.

Another significant role of the case manager is assisting the patient in writing a letter to the donor's family. The case manager should explain that while not every donor family responds to such letters, the gesture is always appreciated. The letter is typically sent to the organ procurement agency, which contacts the donor's family. Responses, if they occur, are usually sent via another anonymous letter.

Finally, returning to work after 6 months post-transplant is possible, and the case manager should encourage this if the patient was working before the transplant. The case manager can collaborate with the employer to arrange light duty and rest periods for the first few weeks after returning to work. Such employment changes allow the patient to resume work activities while increasing strength and endurance.

Ethical Considerations

When providing care for patients who have undergone a liver transplant, case managers must uphold the ethical concepts of nonmaleficence (do no harm), beneficence (taking positive action to help others), autonomy (respecting the right to self-determine a course of action), and fidelity (keeping commitments or promises). The ethical framework provided by the Commission for Case Manager Certification (CCMC) and the Certified Disability Management Specialist (CDMS) Codes of Conduct highlight these principles. Specifically, Principle 2 calls for respecting the rights and inherent dignity of all patients, Principle 3 mandates maintaining objectivity in patient relationships, and Principle 4 requires acting with integrity and fidelity in all interactions with patients and others.

Summary

A holistic approach to case management ensures that liver transplant recipients receive the comprehensive support they need to navigate the complexities of recovery, ultimately leading to a successful and sustained post-transplant life. While it may take up to a year for a liver transplant recipient to feel fully healthy, many go on to live normal, active lives, participating in activities like sports, exercise, socializing, and traveling for both business and pleasure. Advances in anti-rejection medications have significantly improved the success rate of liver transplants. Though recovery can be challenging, recipients may live over 30 years postoperatively. However, complications such as infection, rejection, and disease recurrence are common after liver transplantation. If left untreated, these issues can lead to graft failure, increased morbidity, and mortality. Therefore, close follow-up by the transplant team is essential for preventing, early diagnosis, and treating these complications. CE 3

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References

Butt, S. P., Kumar, A., Ashiq, F., Minou, A., Iuppa, G., & Quintini, C. (2024). Venovenous bypass in liver transplantation: exploring the benefits, efficacy, and safety. *Journal of ExtraCorporeal Technology,* 56(2), 77–81. https://doi.org/10.1051/ject/2024005

Cleveland Clinic. (2024, May 1). *Hepatitis*. https://my.clevelandclinic.org/health/diseases/hepatitis

Finger, E. B. (October 5, 2023). *Organ preservation: practice essentials, historical background, pathophysiology of organ preservation.* Medscape. https://emedicine.medscape.com/article/431140-overview?form=fpf

Halliday, N., & Westbrook, R. H. (2017). Liver transplantation: post-transplant management. *British Journal of Hospital Medicine,* 78, 278–285. doi.org:/10.12968/hmed.2017.78.278

Hertl, M. (2022, August 9). *Liver transplantation.* Merck Manual Professional Edition. https://www.merckmanuals.com/professional/immunology-allergic-disorders/transplantation/liver-transplantation?query=liver%20transplant#Complications_v8495169

Mayo Clinic. (2024, January 19). *Living-donor liver transplant—type.* https//www.mayoclinic.org/tests-procedures/living-donor-liver-transplant/pyc-20384846

Mayo Clinic. (2024, June 3). *"Liver in a box" offers potential for providing liver transplant to more patients.* https://www.mayoclinic.org/medical-professionals/transplant-medicine/news/liver-in-a-box-offers-potential-for-providing-liver-transplant-to-more-patients/mac-20533186

MCG Health. (2024, March 27). *Evidence-based care guidance and solutions.* https://www.mcg.com/

Organ Procurement and Transplant Network (OPTN). *Data reports.* (n.d.). HRSA. https://optn.transplant.hrsa.gov/data/view-data-reports/

Ostojic, A., Petrovic, I., Silovski, H., Kosuta, I., Sremac, M., & Mrzljak, A. (2022). Approach to persistent ascites after liver transplantation. *World Journal of Hepatology,* 14(9), 1739–1746. https://doi.org/10.4254/wjh.v14.i9.1739

Terrault, N. A., Francoz, C., Berenger M., et al. (2023, July). Liver transplantation 2023: status report, current and future challenges. *Clinical Gastroenterology and Hepatology,* 21, 2150-2166. https://pubmed.ncbi.nlm.nih.gov/37084928/

United Network for Organ Sharing (UNOS). (2023, November 27). *Liver paired donation.* https://unos.org/transplant/liver-paired-donation/#:~:text=What%20is%20liver%20paired%20donation%2C%20or%20liver%20swap%3F,to%20find%20a%20better%20match

United Network for Organ Sharing (UNOS). (2024, July 30). US organ transplantation. UNOS. https://unos.org/https://transplantliving.org/

United Network for Organ Sharing (UNOS). (n.d.) Liver-paired donations—LPD. https://unos.org/transplant/liver-paired-donation/

University of California San Francisco. (n.d.) *Transplant surgery: liver transplant: conditions and procedures.* https://transplantsurgery.ucsf.edu/conditions-procedures

Legal Updates By Elizabeth E. Hogue, Esq.

Former Hospice Patient Found With Skin Adhered to Mattress

On December 31, 2024, first responders to a medical emergency at a home in Augusta, Maine, found an elderly woman in a state of severe neglect. The eighty-two-year-old was incoherent when she was found. Her skin was physically adhered to her mattress due to untreated bedsores. The woman was transported to the hospital and stabilized. Her daughter, with whom she resided, was charged with neglect of a disabled or elderly adult. The daughter previously terminated hospice services but then failed to properly care for her mother.

Although this case is particularly egregious, the U.S. Department of Health and Human Services (HHS) points out that at least one in ten older adults experience some form of maltreatment each year. All providers have been involved in situations in which adult protective services are needed. Case managers/discharge planners in hospitals and long-term care facilities are especially likely to encounter and be expected to assist with situations involving adult protective services (APS).

Providers of services to patients in their homes, including home health agencies, hospices, home medical equipment (HME) companies, and home care or private duty companies, are on the "front lines" in reference to identifying situations in which APS is needed. At least anecdotally, however, providers have received little assistance and support from APS in situations of abuse and neglect. Nonetheless, many state statutes require providers to report cases of possible abuse. Whether or not APS takes action, providers must satisfy their obligations to report potential abuse and/or neglect.

continues on page 24

The Case Management Society of America (CMSA) Celebrates Its 35th Anniversary *continued from page 5*

Exclusive Opportunity

For the first time, attendees will have the exclusive opportunity to hear about original research conducted by Dr. Colleen Morley, Dr. Ellen Fink-Samnick, and Dr. Lisa Parker-Williams. This pioneering research delves into the professional identity of case managers, exploring how external factors, organizational structures, and evolving healthcare environments shape the roles and development of case managers. We are excited to present the results of this year-long survey on the case managers' perspective of professional identity. It promises to offer invaluable insights that can help shape the profession's future and empower case managers in their practice.

Recognizing the Vital Role of Case Managers in Healthcare

We are vital to the healthcare system, serving as patient advocates and navigators. We manage complex cases, coordinate interdisciplinary care teams, and focus on holistic care that addresses medical and non-medical needs. Our efforts lead to better outcomes, increased patient safety, and improved patient satisfaction.

This conference will highlight the essential role of case managers in ensuring patient safety and achieving superior healthcare outcomes. Sessions and discussions will explore how case management contributes to all care models, highlighting our alignment with broader healthcare goals of quality improvement and cost efficiency.

Registration and Discounts

Registration is open at cmsa.societyconference.com/v2/ for both Main Conference and Pre-Conference options (Leadership Panel, Writer's Workshop, MVD Day, or CCM Prep Workshop with Nancy Skinner). Early-bird registration is open through 4/29/25, offering exclusive discounts for attendees who register in advance. CMSA members can combine the early bird discount with a $200 member discount, resulting in significant savings.

Venue and Accommodation

The conference will be held at the Hilton Anatole in Dallas, Texas, a premier venue known for its exceptional facilities and convenient location. Attendees are encouraged to book rooms early to secure preferred lodging options. (Water Park and Lazy River, anyone?)

Why Attend?

Attending the CMSA 35th Anniversary Conference offers numerous benefits:

- **Professional Development**: Gain insights into the latest advancements and best practices in case management.
- **Networking:** Connect with peers, industry leaders, and innovators in the field.
- **Celebration:** Join us in celebrating a significant milestone in CMSA's history: 35 years of dedication to case management.
- **Innovation:** Explore cutting-edge solutions and technologies that can enhance your practice.
- **Recognition:** Celebrate case managers' indispensable role in improving patient care and safety.
- **Exclusive Insights:** Learn first-hand about groundbreaking research on the professional identity of case managers from leading experts in the field.

The CMSA 35th Anniversary Conference in Dallas is poised to be a landmark event, offering unparalleled opportunities for learning, networking, and celebration. Whether you are a seasoned professional or new to the field, this conference provides valuable experiences to advance your career and contribute to the future of case management. Don't miss this opportunity to join a vibrant community dedicated to excellence and innovation in case management. For more information and to register, visit the official conference website cmsa.societyconference.com/v2/. CM

Individuals who adopt a passive communication style often prioritize politeness and may hesitate to express their true feelings to avoid conflict or offending others.

Empower Case Managers to Address Workplace Bullying
continued from page 10

crucial for responding in a measured and appropriate manner.

In such situations, scripting becomes a powerful strategy for effectively managing incivility. Individuals can engage their prefrontal cortex by preparing and rehearsing responses to standard forms of incivility—such as yelling, threats, intimidation, and arguments. This preparation bypasses the immediate, reactive responses driven by the amygdala and ensures that reactions align with professional standards, fostering a respectful and constructive environment. Example scripts are:

- "I'm offended by what you just said" or "I'm not sure you realize it, but you can come across as condescending.'
- "Help me understand. I'm willing to discuss this situation with you as long as you are willing to communicate with me respectfully."
- Effectively confronting incivility requires a structured approach. Begin by clearly identifying the uncivil behavior. Then, choose a response script that fits the specific behavior. Regularly practice the selected script to ensure it can be confidently and professionally delivered. Preparation allows for a composed and assertive response to incivility, fostering a workplace or environment that values respect and professionalism.

Conclusion

Case managers are indispensable members of the healthcare interprofessional team, vital for ensuring seamless coordination and delivery of high-quality patient care. Their expertise and unique perspective are pivotal in navigating the complexities of patient needs, resource allocation, and interdisciplinary collaboration. It is imperative for case managers to confidently address and manage incidents of incivility, whether from healthcare professionals, patients, or their families. This assertiveness upholds professional standards and cultivates a collaborative environment for optimal patient outcomes. By advocating for respectful interactions and communication, case managers reinforce the shared goal of the entire healthcare team: providing the highest quality of care to every patient. CE 1

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References

American Nurses Association. (2015). Code of Ethics for Nurses with Interpretive Statements. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

American Nurses Association. (2015). American Nurses Association Position Statement on Incivility, Bullying, and Workplace Violence. https://www.nursingworld.org/~49d6e3/globalassets/practiceandpolicy/nursing-excellence/incivility-bullying-and-workplace-violence--ana-position-statement.pdf

American Organization for Nursing Leadership, AONL Foundation, and Joslin Insight. (2023). AONL Longitudinal nursing leadership insight study (L5). https://www.aonl.org/system/files/media/file/2024/01/AONL-Longitudinal-Nursing-Leadership-Insight-Study-5-Report_v5_0.pdf

Commission for Case Manager Certification. (2023). Code of Professional Conduct for Case Managers. https://ccmcertification.org/sites/ccmc/files/docs/2023/Code%20of%20Professional%20Conduct%20for%20Case%20Managers%20FINAL%202023.pdf

Gonzales, M. (2024). Workplace incivility is more common than you think. *Society for Human Resource Management (SHRM)*. https://www.shrm.org/topics-tools/news/inclusion-equity-diversity/workplace-incivility-shrm-research-2024

Porath, C. (2022). Frontline work when everyone is angry. *Harvard Business Review*. https://hbr.org/2022/11/frontline-work-when-everyone-is-angry

The Joint Commission. (2021). The Joint Commission sentinel event alert. Behaviors that undermine a culture of safety. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-40-intimidating-disruptive-behaviors-final2.pdf

"Although not medically licensed, technicians are trained to recognize health or medical issues and social determinants of health. I feel they do an amazing job collecting as much data as possible, which allows CMs to assist the members with what is needed."

Nail Technicians as Community Health Workers: Amplifying Case Management Success *continued from page 14*

human expertise with technological innovation. Belle technicians already utilize smartphone cameras, and the company will soon launch a suite of AI tools to help nurses detect complications early (such as skin ulcers and circulatory issues) from patient photos and technician documentation. They plan to use the improved data, combined with CM best practices, to further optimize workflows resulting in improved member health and technician and CM experiences. CE2

References

Knowles M, et al. (2023). Community health worker integration with and effectiveness in health care and public health in the United States. *Annual Review of Public Health,* 44:363-381. https://doi.org/10.1146/annurev-publhealth-071521-031648.

Lewin S, et al. 2010. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database Syst Rev*. CD004015. doi: 10.1002/14651858.CD004015.pub3.

National Academy for State Health Policy (NASHP). State Community Health Work Policies. April 2, 2025, https://nashp.org/state-tracker/state-community-health-worker-policies/.

National Institutes of Health. Role of Community Health Workers. December 16, 2020. https://www.nhlbi.nih.gov/education/heart-truth/CHW/Role.

Palmer KNB, et al. (2022). Hair stylists as lay health workers: Perspectives of Black women on salon-based health promotion. *Inquiry*,59:469580221093183. doi: 10.1177/00469580221093183.

Legal Updates

Former Hospice Patient Found With Skin Adhered to Mattress *continued from page 21*

On May 7, 2024, HHS stepped in to strengthen state APS by issuing a final rule establishing the first federal regulations for APS. The regulations took effect on June 7, 2024. The entire rule is at https://acl.gov/apsrule. One goal of the new regulations is to promote high-quality APS that better meet the needs of adults who experience or are at risk of maltreatment and self-neglect. Another goal is to improve consistency in services among the states.

State and local governments have historically funded APS services. There has been wide variation in APS services and practices between and even within states. New regulations and recent funding from HHS to state APS programs now make it possible to improve consistency.

The APS final rule:

- Requires responses within twenty-four hours of screening cases that are life-threatening or likely to cause irreparable harm or significant loss of income, assets, or resources
- Requires APS to provide at least two ways, at least one of which must be online, to report maltreatment or neglect twenty-four hours a day, seven days per week
- Promotes coordination and collaboration with state Medicaid agencies, long-term care ombudspersons, tribal APS, law enforcement, and other partners

Hopefully, providers can look forward to more excellent assistance because of enhanced funding and standards. CM

A Case Manager's Journey: Getting Certified, Staying Certified, Developing Others

continued from page 4

Getting Certified, Staying Certified

I pursued the Certified Case Manager (CCM) credential as part of my professional development. My inspiration was my mother, Shirley Tindal, a registered nurse credentialed in her neuroscience specialization. She encouraged me to seek out certification as a professional aspiration. In 2014, I proudly earned the CCM credential, which set me on a path that the Commission defines for all professional case managers. It starts with *Get Certified*. The journey then continues with *Stay Certified*.

As the care coordination program expanded, so did opportunities to implement case management innovatively. I implemented the Collaborative Care Model frequently used in integrated care, led various initiatives to address social determinants of health, caregiver burnout, and care navigation, and partnered with multiple community stakeholders to link clinical and social strategies. With each role came another opportunity to demonstrate the value of case management to the individuals who receive services, other providers on the care team, and the organization. As Vivian Campagna, DNP, RN, CCM, CMGT-BC, ICE-CCP, who is the Commission's Chief Industry Relations Officer, and Kendra Greene, MSN, MBA/HCM, RN, CCM, Commissioner, wrote recently, "Case management … is a leadership calling. At a time when more emphasis is being put on the role of all leaders across health and human services, case managers are increasingly being called on to demonstrate leadership."

In 2023, my career path led me in a new direction, out of acute care and into a health plan that serves over 1.3 million members. Currently, I am Senior Director of Care Management, working across all lines of business, including managed Medicare and Medicaid, individual products, and commercial groups. In this role, I oversee care management to help ensure that our organization meets our outcome goals, such as reducing avoidable hospital admissions and readmissions and decreasing unnecessary emergency department visits. I am proud to be part of an interprofessional team of about 150 nurses, social workers, community health workers, and other health professionals.

Developing Others

Throughout my career, I've had the opportunity to help others pursue case management roles and develop as certified professionals. Such experiences are aligned with the Commission's third step along the professional case manager's career path: *Develop Others*.

One episode stands out in my memory from my days at the hospital where I worked for 14 years. As we revamped our case management model, we decided to include a requirement for certification. At first, there was pushback. I took this as an invitation to explain to others the benefits I had received from becoming certified. This dialogue led to board certification in case management being included in the job requirements. In addition, the hospital provided study groups for those pursuing certification and reimbursement for those who earned the credential by passing the certification examination.

Having benefited professionally and personally from my journey as a CCM, I have been motivated to find ways to give back to our profession. I became involved with the Commission, including as a speaker at its annual Symposiums that offer continuing education and professional development to case managers. In addition, starting with the 2024-2025 term, I was elected as a Commissioner, serving with a dedicated group of talented professionals. As a new Commissioner, I am learning much from my distinguished peers about case management delivery across health and human services. In addition, I have begun educating myself about the allied field of disability management, which seeks to mitigate the impact of disability on employees and employers.

Within this group of fellow volunteer Commissioners, I am experiencing an extension of what I felt from the moment I became a CCM: I am part of a large and growing community of professionals who span diverse disciplines and backgrounds. Although our experiences differ, we find common ground in case management at a time when these services are more important than ever to help stakeholders—consumers, payers, and providers—achieve their desired goals. CM

Celebrating 30 Years
continued from page 2

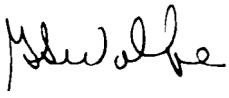
new knowledge for the reader. So many people have a story to tell. Storytelling is the art of conveying a narrative through words, visuals, and experiences to engage and educate an audience. It is a powerful and timeless process that captures the reader. Storytelling is the interactive art of using words to reveal a story. We have told many stories. We tell stories about emerging, new, and current ideas and issues in case management. Sometimes, we bring articles about new developments in science: new diseases and new treatment approaches. Sometimes, we focus on the case management process: new strategies and techniques to improve the process. Sometimes, we bring you articles about the ethical dilemmas in case management. Our articles have covered an extensive range of topics. We are always looking for authors with a story to tell. Do you have a story to share? I am deeply indebted and grateful to our authors. Thank you!

In every issue, we dedicate space to our partners, the Case Management Society of America (CMSA) and the Commission for Case Manager Certification (CCMC) to bring you first-hand information about their organizations and their essential roles in the professional practice of case management. CMSA sets standards, provides education, is a voice of case management, and brings case managers together. The Commission for Case Manager Certifications, representing CCMS and CDMS, is the largest certifying body for case managers and focuses on improving practice with standards for case manager certification. In each issue, these organizations contribute a column that brings the reader current information. Thank you!

To all the people who appear on our masthead: Executive Editor Catherine M. Mullahy, RN, BS, CCRN, CCM, FCM; Contributing Editor: Elizabeth Hogue, Esq. writing our Legal Column; Copy Editor: Jennifer George Maybin, MA, ELS; Art Director Webmaster: Laura Campbell, who has been in that position since the beginning; the Editorial Board, who are case management leaders; Jacqueline Abel, Senior Vice President of Finance and Administration; I say thank you with appreciation and gratitude for your work. It is because of these individuals that the journal becomes a reality.

The future is before us! Although we are currently faced with uncertainties in healthcare, we understand the challenges that you, our readers, and the entire healthcare community are facing. The demands for a healthy life are growing; the delivery of care is becoming more complex; the science and treatment of disease and health are rapidly evolving; and the demand for well-educated case managers can barely keep up with the pace of growth and change. All of these trends demonstrate the need for *CareManagement*. We are committed to supporting you in these challenging times and beyond.

CareManagement looks forward to the next 30 years with anticipation and excitement. The future is great but challenging and demanding. We will continue to focus on our mission: improving the professional practice of case management through education. Thank you, and happy anniversary!



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

ACCM: Improving Case Management Practice through Education

Collaboration…Overcoming Resistance and Achieving Success!
continued from page 3

One of the most critical trends in case management is the shift from a provider-driven to a client-centered approach. This means that case management services need to be tailored to the individual goals, preferences, and strengths of our clients/patients rather than following a standardized or predetermined plan. This client-centered approach can enhance rapport, trust, and engagement among our clients and improve their satisfaction, motivation, and self-efficacy.

As we look forward to warmer months and continuing opportunities for education, consider attending the 35th celebration of our professional association, Case Management Society of America, in Dallas, TX, June 24–27, 2025. I encourage you to attend. I look forward to seeing you there!

Together, through education, interprofessional collaboration, and networking, we can strive for excellence and make a difference…one patient at a time!

Warm regards, Catherine

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

Readers

Have an idea for an article? Send your suggestions for editorial topics to:
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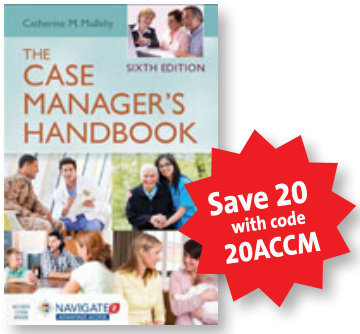
Case Managers: There's no better time to advance your career than now!

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

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



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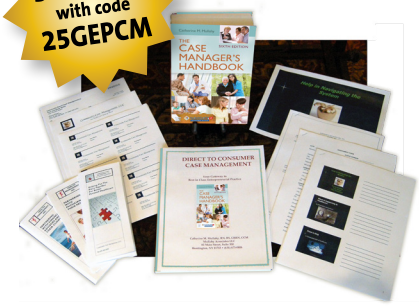

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A: If you submit all of the CE home study programs offered in *CareManagement*, you will accumulate 90 CE credits every 5 years.

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Q: Where can I get my membership certificate?
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Q: How long does it take to process CE exams?
A: Online exams are processed instantly. Mailed exams are normally processed within 4 to 6 weeks.

Q: Do CE programs expire?
A: Continuing education programs expire approximately 6 months from date of issue. Continuing education programs that offer ethics CE credit expire in 1 year.

Q: Is your Website secure for dues payment?
A: ACCM uses the services of PayPal, the nation's premier payment processing organization. No financial information is ever transmitted to ACCM.

application on next page

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