CareManagement

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Vol. 30, No. 5 October/November

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It can be challenging to know when a person with dementia is depressed because many of the symptoms of dementia mimic those of depression. Authors Scruggs and Walters highlight the complex, challenging, and intimidating journey for persons living with dementia and for their care partners and suggest how care managers can help them navigate the health care system.

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Gary S. Wolfe

Celebrating Case Managers

National Case Management Week

National Case Management Week is October 13–19, 2024. The theme is "Case Managers: Powering the Future of Healthcare." What an appropriate theme. Delivering health care has turned into chaos. Assessment, treatments, outcomes, and nearly everything have become more complex in health care. This complexity and associated care delivery has created chaos and confusion. Case managers are at the forefront in leading changes needed to deliver the expected value-driven health care. The case manager knows first-hand what I am talking about. Hardly anything is simple when it comes to health care. There are so many providers, options, choices, and decisions a patient must make in a fragmented system or no system at all. Case managers make a difference in delivering the value-based health care that patients demand.

> **Case managers must showcase their value by communicating and demonstrating their impact on health care delivery. Communicating value means we first must understand the meaning of value.**

Using the case management process, case managers identify, assess, plan, implement, and evaluate every patient based on the patient's beliefs and values and considering the patient's input to determine what is best for that patient. Through engagement, education, and support, the case manager is with the patient and family, helping them achieve their desired outcome(s).

Being a case manager is complex and challenging. The case manager must be well prepared and keep abreast of health care and delivery developments. The future of case management rests in our hands, and we must look ahead to how best to deliver case management services. To look to the future, we celebrate National Case Management Week by sharing our stories about what we do. This week provides an opportunity to talk about what you do and why to your patients, families, colleagues–yes, everyone you encounter. Everyone needs to know and understand your role.

Case managers must showcase their value by communicating and demonstrating their impact on health care delivery. Communicating value means we first must understand the meaning of value. Only then can we describe our value to and impact on case management. We demonstrate value every day. In this issue of *CareManagement*, we publish an article, "Articulating Your Individual Value as a Professional Case Manager," by Hussein M. Tahan, PhD, RN, FAAN, FCM. I recommend this article to you. It will give you some insight into how to tell your own story.

CMSA Fellow in Case Management

One way to celebrate National Case Management Week is by applying to become a Fellow in Case Management for the Class of 2025. The application

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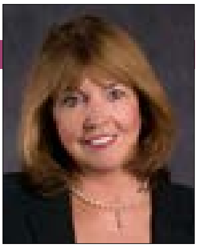

Catherine M. Mullahy

Case Management Stress in an Already Stress-Filled World…How Are You Coping?

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

After the COVID pandemic, many health care professionals left their bedside roles for what they envisioned and anticipated would be a more manageable life as a case manager…fulfilling and meaningful, yet, without the physical demands and emotional factors that take their toll even on seasoned professionals.

We don't need to be told that we're living in a world facing a growing number of events that are impacting our lives and increasing the very real stress we are experiencing. From the increasing crisis between Iran and Israel with threats of a nuclear war; the ongoing war between Russia and Ukraine; threats from countries who are not our friends (eg, China); growing incidents of terrorism, and too much more, the world has certainly become more problematic and stressful. Of course, and likely much closer to us, are the devastating losses of lives and entire communities in the southeastern states following the most recent hurricanes Helena and Milton…with more damage likely to be disclosed. Crimes in our cities, economic insecurities, growing incidents of antisemitism, and other hate crimes all contribute to our feelings of insecurity and anxiety. Our country is also preparing for another election, and this one, as have others that preceded it, results in increased stress as each party attempts to convince others that they have the answers to the problems our country is facing, and much of this is not done in the most peaceful and civilized manner, including more recently, two threats of an assassination of a presidential candidate.

As you are reading this issue, you are possibly thinking about the growing demands that you have as a case manager, and sadly some of you are wondering if you can continue to function in those roles. Perhaps you are contemplating leaving your position. Case management, no matter what practice setting, has caused case managers new levels of stress. After the COVID pandemic, many health care professionals left their bedside roles for what they envisioned and anticipated would be a more manageable life as a case manager…fulfilling and meaningful, yet without the physical demands and emotional factors that take their toll even on seasoned professionals.

To prevent and hopefully resolve the stress being experienced by case managers and prevent burnout and the shortages that would result from those who leave their positions, some steps should be considered:

1. Identify the sources of stress: it's important to identify the sources and triggers of your stress. These can come from a wide range of factors, such as organizational, interpersonal, personal, and environmental. Some of what you might be experiencing may be influenced by unrealistic expectations, conflicting demands, lack of support, difficult clients (and there are growing numbers of those) and your own personal issues. By identifying the sources of stress, you can prioritize and address the most important ones. This important and first step is identical to the first step in the case management process—ie, identify and then manage the risk.
2. Practice self-care: self-care is essential for case managers as it helps you maintain your physical, mental, and emotional health. There are several activities such as eating well, exercising, meditating, doing hobbies, and socializing that are helpful, but equally important are those activities that involve setting boundaries, saying no (yes, you can do that!), delegating tasks, and acknowledging that each of us has limitations.
3. Seek support and supervision: case managers often work in isolation which can increase the risk of stress and burnout. It's important, therefore, to seek support from your colleagues, managers, mentors and peers…whether onsite or virtually. This kind of contact can provide you with feedback, guidance, advice, validation, and input, especially,

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NEWS FROM

THE COMMISSION FOR CASE MANAGER CERTIFICATION

From ICU to Case Management Operations: Passion for Meeting the Needs of People and Their Support Systems

By Kendra Greene, MSN, MBA/HCM, RN, CCM

From my earliest days in nursing, I have been drawn to at-risk patient populations. As a senior in nursing school, I requested a preceptorship in the intensive care unit of a teaching hospital, working alongside an experienced intensive care unit (ICU) nursing supervisor. It was a formative assignment that taught me so much about providing care for individuals with complex needs.

> **Advocacy extends beyond the patients (as they are known in acute care, or clients in other practice settings); the focus also needs to be on the support system/family and their needs.**

Advocacy extends beyond the patients (as they are known in acute care, or clients in other practice settings); the focus also needs to be on the support system/family and their needs. As I saw every day in the ICU, emotions run high as both patients and their loved ones confront their fears of the unknown, as well as their hopes and expectations. I gave quiet support—holding a hand, putting my arm around a shoulder—just to let people know they were not alone in what they were facing. Empathy was needed just as much as the information to understand diagnoses, prognoses, treatments, and interventions.

One of the best descriptions of this "emotional territory" is from Vivian Campagna, DNP, RN, CMGT-BC, CCM, ICE-CCP, and Ellen Mitchell, MA, RN, CCM, of the Commission for Case Manager Certification (CCMC), in their recent Professional Case Manager article: "Grief, anger, sadness, and guilt are all common when clients are diagnosed with chronic and life-altering diseases and conditions. In addition, a person who is overwhelmed and distressed following a serious accident or other trauma may find it extremely difficult to process all that has happened, let alone participate in care planning. In addition, family dynamics and changes in financial or social status can impact the client's mental and physical health and ability to cope and care for themselves."

Their words capture what my ICU experience taught me about the importance of becoming highly attuned to the physical, mental, emotional, and spiritual needs of every individual and their support systems. This is the specialization I brought with me as my career progressed, across acute and subacute care settings, and into case management and now consulting with providers.

After starting my career in ICU, I took a second job as a supervisor in a long-term care facility for children, many of them with complex health challenges. In the beginning, I had my doubts whether I was ready for such a challenging position, but it was surely ready for me. Only two of the children in my care could speak. Despite our differences in communication, we found other ways to connect, such as with eye contact, facial expressions, and touch. These little nuances meant so much and sometimes even more than the actual interventions.

My next job brought me back into the hospital setting as an assistant unit manager on a floor, one side of which was for medical/surgical patients and the other for those receiving telemetry related to cardiac treatments. From there, I worked at a 160-bed rehabilitation facility as a nurse supervisor, overseeing a staff of nurses and nursing assistants.

About this time, I began exploring case management as an advanced practice. It is a logical progression for many nurses, who also pursue case management and become Certified Case Managers (CCMs). For me, attaining CCM certification allowed me to quantify and attest to what I had already been doing in my career:

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Kendra Greene, MSN, MBA/HCM RN, CCM, *is a Commissioner and Chair-Elect of the Commission for Case Manager Certification, the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists. The Commission oversees the process of case manager certification with its CCM® credential and disability management specialist certification with its CDMS® credential. A registered nurse for more than 18 years, Kendra is also a Manager for the Advisory Services team of Optum/UnitedHealth Care.*

Understanding CDMS Knowledge and Skills

By Patricia Nunez, MA, CRC, CDMS, CCM

As a research-based certification, the Certified Disability Management Specialist (CDMS) credential attests to the knowledge and skills of certified professionals in assisting injured or ill employees and those with disabilities to stay at work, return to work, preserve their wages, and contribute to their employers' productivity. Two areas in which board-certified disability management specialists have expertise follow.

Opportunities for cost savings for employers can often be found within extensive leave, claims, and similar employer data. Such data can also shed light on trends within teams, job classifications, business units, communities, and other groups.

Disability and Work Interruption Case Management

This includes comprehensive analyses of individual cases to determine the impact on functional capacity due to illnesses, injuries, or mental health conditions; developing individualized retention plans for the impacted worker; and leveraging benefits, services, and community resources to support and facilitate optimal functioning.

Individualized interventions result in cost savings for the employer by limiting the duration of disability claims through targeted wellness, mental health, and rehabilitation plans and programs.

Such interventions support not only the employee but also their support system and family, coworkers, and managers as the individual transitions back to or stays at work. For the employee, these interventions allow them to remain productive and earn their regular wages. Examples of interventions include return-to-work (RTW) and stay-at-work programs, which are widely used by employers in both the public and private sectors. These programs benefit individuals who preserve their earning power, as well as employers who keep experienced and skilled workers on the job.

Workplace Intervention

Compliance with federal, state, and local regulations provides a baseline, which is further enhanced by an interactive process that supports an employee's ability to function in the workplace or pursue vocational rehabilitation to train for a more suitable position. Prevention also plays a part here by identifying ergonomic, safety, and accessibility issues in the workplace and implementing solutions to minimize risks and avoid loss.

Opportunities for cost savings for employers can often be found within extensive leave, claims, and similar employer data. Such data can also shed light on trends within teams, job classifications, business units, communities, and other groups. A skilled CDMS who can facilitate the data analysis is able to present a business case for implementing programs and services that will favorably impact the employee experience, reduce claim and health care costs, bolster productivity, and improve the employee's socioeconomic stability. For example, the accommodations or modifications that support ill or injured employees and those with disabilities can also inform broader interventions to support health, wellness, and injury prevention among a broader population of workers.

In summary, board-certified professionals who hold the CDMS credential attest to their knowledge and expertise in workplace interventions and other services and solutions. Through their support and advocacy, board-certified disability management specialists help provide more opportunities for employees with illness, injuries, and disabilities and preserve the productivity of employers.

Patricia "Patty" Nunez, MA, CRC, CDMS, CCM, *is Chair (2024-2025) 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. Patty recently retired as a director within the Claim Vendor Management office of CNA and is based in southern California.*

Igniting the Power of Case Management: Celebrating Case Management Week 2024

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

Get ready to celebrate, Case Managers! Case Management Week 2024 is here, and it's shaping up to be an incredible opportunity to come together, recognize our achievements, and look toward the future of health care. As we power into this celebratory week, scheduled from October 13–19, we honor the passion, expertise, and dedication that drives our profession. This week isn't just a time for reflection—it's a time for inspiration, education, and deepened connections with our fellow professionals. The theme this year says it all: "Powering the Future of Healthcare."

> **CMSA, founded in 1990, established Case Management Week to provide a platform to recognize and celebrate the pivotal role case managers play in health care.**

A Legacy of Recognition: History of Case Management Week

Case Management Week (CM Week) has a rich history that traces back to its official recognition by the Case Management Society of America (CMSA) in the 1990s. CMSA, founded in 1990, established Case Management Week to provide a platform to recognize and celebrate the pivotal role case managers play in health care. As the case management profession grew, so did the importance of this dedicated week, becoming a time when case managers from diverse health care settings—acute care, managed care, workers' compensation, and community-based care—come together to raise awareness about the critical contributions we make to patient care.

Initially focused on educating the public and health care community about the value of case management, CM Week has evolved into a full-fledged event packed with educational opportunities, community engagement, and celebrations. CMSA officially sponsors and promotes this week-long observance each year, allowing case managers nationwide to feel a sense of pride and unity. Over the years, CM Week has become a momentous occasion where professionals celebrate their successes, share innovative practices, and continue to drive the field forward.

A Week of Learning, Connecting, and Celebrating

Here's a sneak peek at some of the exciting events planned for CM Week 2024, designed to inspire and equip us with new knowledge and skills.

Sunday, October 13, kicks off the week with a CM Week Treasure Hunt, encouraging you to connect with your community while engaging in some fun. This is your chance to interact with case managers from across the country, participate in online activities, and win prizes simply by engaging on CMSA's social media platforms like Facebook, LinkedIn, Instagram, and X (formerly Twitter).

On Monday, October 14, CMSA President Janet Coulter will host a virtual Case Manager Mixer at 5:30 pm ET. It's a perfect moment to toast the practice of case management and celebrate the many accomplishments we've achieved over the past year. After all, what better way to begin CM Week than by recognizing the collective power of our work?

The educational sessions begin on Tuesday, October 15, with a webinar that dives deep into advancing Diversity, Equity, Inclusion, and Belonging (DEIB) in professional case management. This session, led by industry veterans Michael Garrett and Ellen Fink-Samnick, explores how we can push for health equity in our practice. This is an opportunity not only to learn but also to reflect on the ethical dimensions of case management and expand our toolkits for inclusive care.

On Wednesday, October 16, we turn our attention to integrated care with a webinar on primary care and behavioral health. Titled "Better Together,"

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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.

Is Orange the Fashion Statement You Want to Make?

Management Principles, Inc., or MPI, managed 2 Medicare-certified home health agencies. The agencies received a significant number of referrals from the Healthcare Consortium of Illinois. The Consortium contracted with the Department of Aging to help coordinate health care services for low-income seniors. The Consortium identified seniors who needed home health services and referred them to local providers. It maintained a list of approved agencies to which it made referrals on a rotating basis. The agencies managed by MPI were on the list.

As a part of its arrangement with the Consortium, MPI signed a Management Services Agreement. In the Agreement, MPI agreed to pay the Consortium $5,000 per month in exchange for what the Agreement called "management services" and "administrative advice and counsel." After the Agreement was signed, the Consortium gave MPI full access to its clients' health care data. Employees of MPI went to the office of the Consortium several times a week, where they reviewed clients' records, and recorded clients' contact and medical information.

Are you seeing orange yet?

In 2010, MPI devised a scheme to use this information to bypass the Consortium's rotational system of referrals by directly soliciting Medicare beneficiaries who might need home health services. If services were needed, the agencies provided services, billed the Medicare Program, and then split the fee with MPI.

MPI paid the Consortium a total of $90,000 over a period of 18 months. The payments stopped in 2012, but MPI continued to mine the Consortium's records for potential patients. Between December of 2010 and June of 2015, the agencies billed the federal government approximately $700,000 for services provided to patients referred by the Consortium.

By now, definitely orange!

A watchdog organization filed a whistleblower lawsuit against MPI and the agencies it managed. The lawsuit resulted in a judgment against MPI and the agencies of approximately $6,000,000.

Here is what providers need to know about what happened in this case on appeal:

- The Court said that the definition of referrals under the federal anti-kickback statute is very broad, including both direct and indirect means of connecting patients with providers. MPI's activities qualified as a form of indirect referral based on kickbacks.
- Providers that bill the federal government for services performed on patients referred in violation of the federal anti-kickback statute may also be liable under the federal False Claims Act.
- Every claim that is the basis of liability under the False Claims Act must be false by virtue of the fact that the claims are for services that were referred in violation of the anti-kickback statute. Claims for services provided to patients who were not referred in violation of the anti-kickback statute are not false claims.

In this case, patients referred to MPI in the Consortium's normal rotation system were not false claims. CM

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

Federal Regulations for Adult Protective Services

On May 7, 2024, the US Department of Health and Human Services (HHS) issued a final rule establishing the first federal regulations for Adult Protective Services (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.

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

The APS final rule:

- Establishes a set of national minimum standards for the operation of APS programs that all state APS systems meet
- Requires APS systems to ensure that planning and delivery of all services respect the fundamental right of adults to make their own life choices and that services are driven by the person receiving them
- Establishes stronger protections for clients subject to, or at risk of,

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Case Managers Are…

Kelly Archer, BSN, RN, CCM

Case managers are professionals who prevent patients' needs from slipping through the cracks while keeping an entire care team in the loop through effective communication. When working in the primary care setting, quality care measures are more important now than ever before due to changes in reimbursement. It is very challenging to educate and assist providers who have been practicing for 10 + years in transitioning to value-based care instead of fee-for-service. It takes a case manager-led team approach to transform a clinic by implementing quality measures from the receptionist to the provider. Measuring the worth of a case manager is challenging, but with the help of accountable care organizations, providers can see cost savings and losses plainly written, which proves case managers' worth and need.

Case managers are the forefront of quality measures in the clinic. From ensuring compliance with screenings to medication adherence, the entirety of a patient's health is a priority. All people want a high-quality experience wherever service is rendered. Case managers are the key holders to drive the needle up in quality. What is high quality? From a case manager's perspective, it means treating patients with the absolute best care just as if they were your own family member.

Kelly Archer, BSN, RN, CCM, is a RN Care Manager at The University of Alabama. Kelly is also pursuing a master's degree in population health sciences.

> **All people want a high-quality experience wherever service is rendered. Case managers are the key holders to drive the needle up in quality.**

Oftentimes, providers are consumed with paperwork and documentation requirements that there is just not enough time in the day to check if the next patient on the schedule is up to date on the wellness visit, screenings, vaccines, and to ask about memory concerns or fall risks. A simple screening questionnaire by the case manager can easily identify all the gaps in care and barriers to managing care. A quick conversation with the patient can also identify any need for intervention with memory concerns or falls. Let's say a patient is a fall risk and is referred to physical therapy to improve balance. The simple referral for the patient could save thousands in hospital costs should they fall and become injured without the therapy. The autonomy of a certified case manager with a background in healthcare is invaluable and provides an additional resource to the clinic to drive up those quality measures.

Case managers are a muffler for the grumbling of many providers when it comes to additional tasks to improve quality. If a provider is told to add documentation that is required for insurance or to fill out that extra form to earn that bonus, there is some resistance. How can one blame them? The change to value-based care is a paradigm shift. Previously, providers did not have to complete a prior authorization or document all applicable diagnoses each year. Providers were not taught value-based care in their medical training 10-plus years ago. Merging a complex business model into a medical profession of educated providers is very challenging to explain and implement, especially when it's coming from someone who is "just a case manager." Many diagnoses carry an amount of money with them that estimate the cost of managing that condition for one year. If a diagnosis is not documented each year, insurance will think the patient does not have that condition anymore. What if a condition worsens? The case manager, for example, can then take the initiative to point out to the provider that a patient's glomerular filtration rate has worsened and now qualifies as chronic kidney disease (CKD) Stage 4 instead of CKD Stage 3b. If a provider is focusing on managing that fine line of a warfarin dose, a case manager can fill in the gaps and notify the provider of missed screenings and applicable diagnoses to consider. Creating a value-based environment in a fee-for-service world takes knowledge, initiative, and perseverance. Case managers are the driving factor in the clinic to implement quality measures to improve patient care. Once those quarter results come in from insurance payers, providers can then see the worth of case managers dollar for dollar. Patients alike benefit from improved health outcomes and less health care spending.

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Articulating Your Individual Value as a Professional Case Manager

Hussein M. Tahan, PhD, RN, FAAN, FCM

For many decades professional case managers (PCMs) have been crucial in effectively delivering health care services to people, populations, and communities. They add value to a person's experience within the health care environment in multiple ways. Some examples are coordinating patient care activities and treatment plans; advocating for patients, their families, and personal caregivers; ensuring that patients receive the safe, quality, and appropriate services and resources they need; engaging patients in shared decision-making and developing self-management skills; and protecting patient autonomy, self-determination, and independence. Effectively communicating and showcasing our value as PCMs are essential to demonstrating our impact on both patient and health care organization's outcomes, as well as the field of case management practice. In this article, I explore various strategies we can employ to successfully, impactfully, and confidently communicate our value as PCMs.

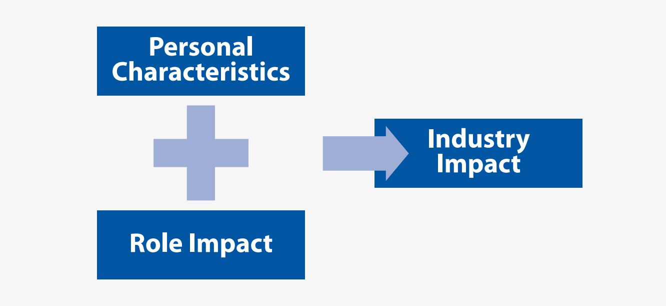
I am fortunate to be one of the inaugural and founding case management fellows (FCM™), the program sponsored by the Case Management Society of America (CMSA). Since its launch in 2021, I have been participating as a member of the fellows' review committee and have contributed to the selection decisions the committee has made. I have observed the need to share how PCMs can articulate their value. Many PCMs are uncomfortable in communicating the impact of the care they provide to patients and families, but more importantly, they do not share their value toward case management at large. I am confident that those who have applied for the credential, achieved the credential, including myself, or perhaps are contemplating future application, have much more to share about their value than what we as a profession believe is sufficient. Therefore, I write this article to stimulate the reader's (and all of us case managers') thinking about our own individual case management value, provoke self-reflection, encourage pursuit of the FCM credential, and engage in dialogue regarding how we may communicate such value to others and within the industry.

Understanding the Meaning of Value

Based on an Oxford Languages dictionary definition, value refers to the importance, worth, or usefulness of something. It also defines value as something deserved, beneficial, and highly meaningful. Because I focus in this article on the individual value and contribution of PCMs, I articulate here my views on value from a single-person frame of reference. When we consider the meaning of value for a person, we see it referring to the beliefs and principles that one considers are important, especially in the way they live, work, and relate to others. On a personal level, then, value refers to what one determines to be of primary interest or as a priority guiding their own decisions and actions. If we apply these characteristics of value to case management and PCMs, we observe that value is evident in 3 ways: personal PCM qualities, role-related impact, and industry impact and contributions of a PCM–that is, the role played to advance case management practice (Figure 1).

On a personal level, what characterizes PCMs may

FIGURE 1 **VALUE OF PROFESSIONAL CASE MANAGERS**



Hussein M. Tahan, PhD, RN, FAAN, FCM, *is the system vice president of nursing professional development & workforce management and chief nursing officer for ambulatory services at MedStar Health, Columbia, MD. Hussein was recognized as a Case Management Fellow in 2021; CMSA also presented Hussein with the Lifetime Achievement Award in 2016. Hussein can be reached at htahanrn@gmail.com.*

TABLE 1 **EXAMPLES OF PERSON-RELATED VALUE (PERSONAL CHARACTERISTICS)**

- Accountability
- Accessibility
- Advocacy
- Achievement
- Caring
- Commitment
- Compassion
- Competence
- Confidence
- Connection
- Discipline
- Emotional Intelligence
- Empathy
- Equity
- Equality
- Ethics
- Excellence
- Independence
- Integrity
- Justice
- Leadership
- Learning
- Organization
- Ownership
- Patience
- Resilience
- Resourcefulness
- Respect
- Responsibility
- Stewardship
- Success
- Transparency
- Trust

comprise a set of diverse values, such as those listed in Table 1. Often, PCMs demonstrate some or all these personal values, or perhaps others not listed here, while interacting with and relating to patients and families, peers, interprofessional colleagues, leaders, and other stakeholders. These values ultimately make the PCM's character and qualify the personal approach to patient care delivery–that is, the context of executing role responsibilities at the individual patient level.

From the perspective of the case management role and industry contributions, we show value through our responsibilities and the scholarly activities we engage in that impact patient care, as well as the local, national, and global practice of case management. Our role-related responsibilities demonstrate value to each individual patient and family we serve, or to the practice environment we are a part of that is often defined as employer-based or role- and title-driven. Our scholarly activities, however, are the significant and far-reaching contributions we pursue for the purpose of advancing case management practice beyond our immediate circle of influence (ie, employer scale) to ultimately benefit other PCMs, the people in our communities, and the field at large.

Professional Case Manager's Role-Related Value

As PCMs, we demonstrate our value every day when executing our role responsibilities of caring for patients and their families, leading a team of health care professionals, including PCMs, and in the care setting where we function. Our individual contributions in our practice settings are numerous, such as those shared in Table 2.

There are other examples of our contributions as PCMs that are also employer-based and not directly related to individual patient care coordination or management. These can be department-wide and may include, but are not limited to, innovations in case management care delivery models; development of policies, procedures, standards, or tools to enhance our practice and improve outcomes; engagement in research or quality improvement activities; orientation, training, and ongoing education of PCMs; or mentoring PCMs who are new to case management practice.

Value Related to PCM Practice and the Field at Large

It is important to extend our value as PCMs beyond our employer-based responsibilities. Our role-related contributions are important and necessary for the advancement of our practice. The magnitude of this value depends on the impact of our contributions on the case management field at large, whether in demonstrating greater influence, broader benefit, wider recognition, or sharing practice innovations. Engaging in scholarly work is also crucial for advancing professional case management. Through these activities, our impact may be evident in enhancing our case management body of knowledge, informing best practices, promoting evidence-based care, advancing the science that supports our work, disseminating experiences of innovation and scientific

TABLE 2 **INDIVIDUAL PCM'S VALUE RELATED TO ROLE IN PATIENT CARE**

- Collaborating with interdisciplinary health care teams across care settings
- Actively participating in care conferences, case reviews, and team meetings
- Sharing valuable insights and expertise to ensure that patients receive comprehensive and coordinated care interventions
- Serving as liaisons between patients, providers, and payers
- Facilitating smooth transitions of care while promoting patient care continuity across health care settings
- Clearly and simply communicating with patients and their families
- Providing patient education about treatment plans, medication management, and available resources
- Advocating for patients and families, and empowering them to make informed decisions about their care
- Maintaining open lines of communication among patients and health care team members
- Addressing any concerns or questions patients may have, fostering trust and confidence in their self-management abilities
- Leveraging data and outcomes to demonstrate the impact of patient care interventions
- Tracking key performance measures such as hospital readmission rates, length of stay, turnaround time for completion of tests, procedures, referrals, or consults
- Communicating outcomes and department performance to various stakeholders, such as hospital leaders and representatives of insurance companies

TABLE 3 **INDIVIDUAL PCM'S VALUE RELATED TO ROLE IN PATIENT CARE**

Contribution Type	Examples
Leadership	• Contributing to professional case management standards of practice and standards of ethics and professional conduct within and external to place of employment • Major contributions that advance the professional practice of case management outside of employment • Recognition of accomplishments by major leaders or professional organizations in the field • Innovative leadership activities or achievements designed to impact the current and future practice of professional case management • Leading multidisciplinary teams or task forces at a regional or national level for the purpose of practice innovation or transformation • Clinical innovations such as developing and implementing new care delivery models, standards, protocols, and interventions aimed to improve patient outcomes and enhance the efficiency and effectiveness of case management processes • Anticipating the necessary changes in case management practice and leading transformation activities to charter the continued evolution of the practice
Service	• Maintaining active membership in case management professional societies and associations; holding an officer position, chapter leadership role, or being a contributor on a regional or national level • Board membership on a case management certifying agency; assuming a role in contributing to certification examination • Volunteer and community service activities; community engagement such as health risk screenings, wellness initiatives to connect with members of the public, and collaborations with local organizations, schools, and faith-based groups • Hosting public health educational workshops and events focused on healthcare navigation and care coordination • Serving on national task forces that aim to advance the practice of case management
Public & Health Policy Advocacy	• Influencing policy design or change at the national, state, or county level for the purpose of impacting health-related social needs, diversity, equity, and inclusion or supporting the needs of patients, caregivers, and healthcare providers • Participating in legislative initiatives and collaboration with policymakers and stakeholders to shape health care policy and regulations • Collecting testimonials and success stories from patients who have benefited from the services of PCMs; sharing these testimonials about an organization's or other websites, in social media channels, and in marketing materials to illustrate the tangible impact of case management on patient outcomes • Partnerships with advocacy groups, professional associations, and grassroots organizations to amplify the message about the value of case management • Role in design or revision of case management-related accreditation standards or development of quality and performance measures used in the evaluation of case management outcomes and relevance to value-based care • Collaboration on advocacy campaigns, policy initiatives, and public awareness efforts to advocate for greater recognition and support for case management practice • Pitching stories to local newspapers, online media channels, radio stations, and television networks, highlighting real-life examples of how PCMs have made a difference in the lives of patients and their families
Education & Professional Development	• Advanced level of education, such as a postgraduate academic degree • Acquiring a case management certification from a nationally recognized certifying body • Acting as a formal mentor to others; supporting the professional development and advancement of team members and others such as students or those new to the practice of case management–contribution to the development of the next generation of PCMs • Participation in ongoing education and professional development activities as a learner or expert speaker • Program development and consistent presentation (poster or oral) at local or national conferences, especially those that have demonstrated an impact on the professional practice of case management • Development and execution of continuing education and training programs, workshops, certification review courses, or webinars to support the professional advancement of PCMs and other colleagues in the industry • Academic partnerships such as collaborations with academic institutions to integrate case management concepts into curricula and continuing education programs, teaching and guest speaking

TABLE 3 (continues next page)

TABLE 3 (continued) **INDIVIDUAL PCM'S VALUE RELATED TO ROLE IN PATIENT CARE**

Contribution Type	Examples
Science and Scholarship	• Research activities focused on studying the impact of case management interventions on patient care outcomes • Leading quality and performance improvement projects or implementing evidence-based practice in care standards and processes of care delivery with the aim to enhance patient outcomes, improve systems of care, and optimize resource utilization • Collaborations with academic institutions, other health care organizations and stakeholders in research activities, innovation, or academic practice • Fostering a culture of knowledge translation and dissemination to the field; for example, facilitating research rounds, journal clubs, interdisciplinary forums for sharing research findings and clinical insights, and public speaking at conferences • Research and evidence-based practice activities to advance the science of case management and contribute to the evidence base supporting best practices, reduction of health disparities, or improving access to care • Public speaking engagements at community events, health fairs, local organizations, symposia, professional meetings, and national conferences to share learnings from research and innovation activities or insights into the work of PCMs and the impact they have on patient care • Original work published in CMSA Today or other peer-reviewed journals, especially those with a strong reputation and wide readership to maximize the impact of the work and reach fellow professionals in the field; focus areas may include research articles, case studies, literature reviews, and clinical practice guidelines • Publication in trade magazines, newsletters, or online media catering to PCMs, health care professionals, and nursing stakeholders. For example, write articles, editorials, and opinion pieces. • Mentoring junior colleagues, students, and aspiring nurse case managers to support their professional development and encourage their involvement in scholarly activities

activities to PCMs in the field, or maintaining the legitimacy and relevance of the practice.

Communicating our value as PCMs to the public and to the case management industry is essential for raising awareness about our role in health care and garnering support for our profession. In this regard, we can showcase our value through various activities such as those described in Table 3, which are divided into unique areas of leadership, service, public and health policy, education and professional development, and science and scholarship. In these efforts, we focus on both the people we care for and serve, our PCM colleagues, other members of the interprofessional health care team, and the various stakeholders.

PCM Value and the Case Management Fellow™ Program

Wolfe shares in a publication that the CMSA Case Management Fellow (FCM™) program "recognizes case management professionals who have made a significant contribution to case management through leadership, service, innovation, and scholarship" (2021, p. 2). Tahan (2022) also emphasizes that the CMSA FCM program acknowledges PCMs who have "contributed significantly to the professional practice of case management … [and that] achieving the FCM status is a testament to someone's profound contribution to, and impact on, the field – regionally, nationally, and sometimes even internationally." CMSA describes the Fellows as PCMs who "take an active role in the identification of future trends and issues affecting case management, serve the public and the case management profession … and exude a passion for the profession" (2024, p.1). Earning the FCM credential indicates a high level of demonstrated proficiency in the professional practice of case management, showing a commitment to knowledge through continuing education and publication. It also establishes Fellows as influencers to the growth of the profession.

In their writings about the fellowship program, CMSA (2024), Tahan (2022), and Wolfe (2021) describe PCMs who hold the FCM credential as thought leaders and strategic thinkers, and of recognized stature in the industry. They also characterize them as visionary practitioners, experts, and leaders who inspire transformation, expand case management knowledge, advance the standards of practice through excellence, engage in a wide array of scholarship activities, and act as ambassadors of the profession. These descriptions exemplify the professional case management practice related value of PCMs. So, becoming an FCM should be a manageable goal for you and a meaningful aspiration–one that recognizes your contributions and acknowledges your value in case management.

If you are interested in becoming a CMSA Fellow, this article presented numerous examples of how you may demonstrate your value, contributions, and impact in the field. These examples are a roadmap that guides you in how you may showcase your accomplishments in the FCM application.

Many PCMs are uncomfortable in communicating the impact of the care they provide to patients and families, but more importantly, they do not share their value toward case management at large.

It is important to share your activities in the areas of leadership, service, public and health policy, education and professional development, and science and scholarship. However, it is necessary to describe your contributions to and impact on the field at large and not just within your practice or employer setting.

Conclusion

By employing the strategies discussed in this article, PCMs can effectively demonstrate and communicate our value to the public. We also can raise awareness about our role in health care, foster greater appreciation for the vital work we do in supporting the delivery of high-quality, holistic, and patient-centered care, and demonstrate our impact on patient safety and care outcomes. It is an obligation and expectation that we disseminate our scholarly work, contribute to the advancement of the field, and promote evidence-based practice in case management and health care delivery. Additionally, by actively engaging in leadership, service, science, public policy, education, and scholarship, we undoubtedly can significantly contribute to the professional practice of case management and drive positive change in the health care system.

Finally, I hope I provided some practical information about the meaning of value in case management and made it clearer for those inspired to pursue the FCM credential. Although I discussed how we may contribute to our practice in diverse areas such as those covered in Table 3, the FCM program does not necessarily expect an applicant to have had impactful presence in every single area. CE1

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Caring for Older Lesbian, Gay, Bisexual, and Transgender Adults: Implications for Case Managers

By Jeffrey Kwong, DNP, MPH, AGPCNP-BC, FAANP, FAAN

In the US, the number of adults 65 years and older who identify as lesbian, gay, bisexual, or transgender (LGBT) is estimated to be 2.4 million; that number is anticipated to increase 7% by 2030 (American Psychological Association, n.d.). Although this population may have many of the same chronic health conditions as their non-LGBT counterparts, older LGBT adults also experience disparities that impact their physical, mental, and social well-being. Awareness of these issues is important for case managers and other professionals who provide direct client services. This article highlights some of the challenges faced by older LGBT adults and provides recommendations on how to care for this population.

Stigma, Trauma, and Minority Stress

Although social and cultural norms regarding sexual orientation and gender identity have evolved, persons over the age of 60 grew up in an era that was significantly different. Today, discussion of sexual orientation and gender identity has become commonplace. There are high school programs for LGBT youth, celebrities and politicians openly identify as LGBT, television and film have LGBT characters, and sexual orientation and gender identity content can be found on multiple social media outlets (Hammack & Wignall, 2023). The generation of adults 60 years or older were raised in a society in which these issues were not discussed. At that time, resources for persons who identified as LGBT were limited; there were no role models to look up to; and those who did openly identify as LGBT were shamed, stigmatized, or subject to violence. Up until 1973 the American Psychological Association considered homosexuality a mental disorder (McHenry, 2022). Given this historical context, it is important to recognize that older LGBT adults spent their formative years in a society in which their sexuality or gender identity was considered taboo, and their feelings of sexual attraction to members of the same sex were considered a psychiatric illness (Hurd et al., 2022).

Additionally, during the early 1980s, members of the LGBT community were disproportionately affected by the HIV epidemic. Many people lost friends, partners, and entire social networks. The impact of these experiences has lasting impressions on those who survived the early days of HIV (Bower, et al., 2019). For some older adults who either never acquired HIV or who were fortunate to have benefited from HIV treatment, the experience of survivor guilt, depression, and posttraumatic stress disorder (PTSD) can contribute to poor mental health.

As health care providers, we must keep in mind how these lived experiences and societal norms impact the way in which older LGBT adults may feel about interacting with health care providers, how comfortable they feel in disclosing their sexual orientation or gender identity to others, or how these events may have lasting impressions on their overall psychological well-being (Fredriksen-Golden et al., 2023).

The minority stress model has been used to describe how persistent experiences of prejudice, discrimination, and victimization negatively affect the mental and physical health of LGBT individuals (Correro & Nielson, 2020). The result of lifelong exposure to this stress is thought to contribute to higher rates of depression, anxiety, alcohol and substance abuse, PTSD, and cognitive decline. To further add to the complexity of these factors on mental health, some LGBT people struggle with not only the public's sentiments of homophobia and transphobia, but also may experience their own internalized homophobia and transphobia. These negative feelings and fear about oneself have been shown to adversely contribute to a person' physical and mental health (McLean, 2021). Additionally, ageism, although not unique to LGBT persons, has been shown to contribute to poor mental health and overall well-being of older adults (Kang & Kim, 2022). All these factors should be considered to fully understand the challenges that older LGBT clients face daily.

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Although social and cultural norms regarding sexual orientation and gender identity have evolved, persons over the age of 60 grew up in an era that was significantly different.

Physical and Mental Health Disparities

Data have shown that LGBT older adults are more likely than heterosexual older adults to experience chronic conditions that affect physical function and are associated with disability and chronic pain (Dawson, Long, & Frederiksen, 2023; Montero et al., 2024). Lesbian and bisexual women have been noted to experience higher rates of obesity, asthma, diabetes, and alcohol use disorder compared with heterosexual women. Anal cancer is 3 times as high among men who have sex with men with HIV (National LGBT Cancer Network, n.d.). In terms of mental health, data from the US Census Bureau found that older LGBT adults experience more anxiety (31% vs 22% for adults 50-64 years; 17% vs 12% for adults 65 and older) and depression (23% vs 12% for adults 50-64 years; 13% versus 9% for adults 65 and older) compared to non-LGBT counterparts (Bouton et al., 2023).

These disparities represent the intersectionality of multiple determinants of health. When exploring the data by race and ethnicity, LGBT adults from racial or ethnic minorities are disproportionately impacted by these disparities compared with Whites. For older transgender and nonbinary individuals, the disparities such as HIV, substance use, and victimization are even more pronounced (Kim et al., 2017).

Financial Security and Housing

Approximately 20% of older lesbian, gay, and bisexual adults live below the federal poverty line (FPL), with 50% of older transgender individuals living at or below 200% of the FPL (Lambda Legal, n.d.; UCLA School of Law Williams Institute, 2023). In a survey of older LGBT adults conducted by the American Association of Retired Persons (AARP), 49% of respondents reported altering their medical treatment due to concerns about finances (AARP, 2022). For example, 19% delayed refilling prescription medications, 17% did not take the full dose of a medication, and 21% avoided seeking specialist care. Compared to their non-LGBT counterparts, older LGBT adults reported being extremely concerned about having enough money to live (51% vs 36%) (National Alliance to End Homelessness, n.d.).

Closely tied to financial security is housing security. Having a home not only provides shelter, but also provides a place that people can feel free from harassment or harm. Older LGBT adults are less likely to own a home compared to non-LGBT older adults (49% vs 64%, respectively), with LGBT-identified Blacks, Hispanic/Latinos, and transgender/nonbinary individuals being less likely to be homeowners (Statista, 2023). Surveys of LGBT adults show that 43% report feeling anxious about finding a community or neighborhood that would be welcoming (Statista, 2022). Until recently, federal housing laws did not specify sexual orientation or gender identity as a protected category against discrimination. In 2021, as part of US Presidential Executive Order 13988, discrimination based on gender or sexual orientation is prohibited under the US Fair Housing Act (US Housing and Urban Development, 2022). This federal-level policy change will hopefully reduce the incidence of discrimination for LGBT adults who wish to obtain or maintain their current residence.

Long-Term Care

Long-term care can also pose a challenge for some older LGBT individuals. Finding services that are welcoming and inclusive of LGBT residents may prove difficult. Reports examining older LGBT individuals who need or who are in long-term care facilities have found that LGBT older adults experience substandard care compared with non-LGBT residents (Buczak-Stec et al., 2022). This has resulted in some older LGBT adults going back "into the closet" out of fear to hide their sexual orientation or gender identity. As a result, these individuals are deprived of the opportunity to live as their authentic selves. Additionally, older LGBT adults are more likely than their non-LGBT counterparts to need long-term care or other aid as they age, primarily due to lack of familial or social support. This provides an added source of anxiety and worry for LGBT older adults (Singleton, et al., 2022).

Challenges of Caregiving

For many LGBT older adults, the structure of caregiving is also different. In the traditional family structures, older adults are usually cared for by their children or other members of the family (Torres & Lacy, 2021). For LGBT

"As health care providers, we must keep in mind how these lived experiences and societal norms impact the way in which older LGBT adults may feel about interacting with health care providers, how comfortable they feel in disclosing their sexual orientation or gender identity to others, or how these events may have lasting impressions on their overall psychological well-being."

persons who may not have children or who may be estranged from their biological family, that level of caregiving support is absent. Instead, older LGBT adults may rely on same-aged peers. This poses a challenge when peers are also struggling or dealing with their own health issues and may not have the same physical capability or resources as those who are younger. Although the number of LGBT persons who have children is increasing, gay men are less likely to have children compared with lesbians and transgender individuals. In a survey of older LGBT people, gay men feared social isolation and being left out more than lesbians or nonbinary adults, who were more likely to have children to help support them as they age (AARP, 2022).

Health Care Systems Issues

Systems-level issues add to the challenges and barriers experienced by older LGBT adults. For example, one of the biggest system-level issues is the lack of health care provider training and education on providing culturally competent care for LGBT individuals. Health professional programs have limited content on LGBT health (Greene et al., 2018). This lack of training results in a workforce that is not adequately prepared to care for LGBT individuals or understand the various facets that influence health conditions (Caceres et al., 2020).

Although many hospitals and health care systems have policies surrounding visitation rights, it is important to know that not all institutions have embraced this practice. LGBT individuals may have "families of choice" (people who are not their biological or legal family) whom they consider their next of kin. Hospital or health care organizations may have policies that restrict who can visit or see a patient if they are hospitalized in a health care facility. These policies may not recognize a patient's same-sex partner as a family member and may limit or restrict visitation or communication (Center for Advancing Progress, 2022).

Implications for Case Managers

Case managers are integral to facilitating continuity of care for older LGBT adults and helping to improve overall quality of life. Having awareness of the issues that shape the life experiences of older LGBT adults is an important first step to becoming competent in caring for this population. The strategies presented here can assist case managers in providing better care for older LGBT adults.

Language Matters

Using nonstigmatizing, gender-neutral language is one of the foundational steps in building a strong relationship (National LGBT Education Center, n.d.). For instance, it is important to ask clients how they wish to be called or what name they prefer. Especially for transgender individuals, the name and gender on health insurance or medical records may differ from the client's current identity.

Additionally, terms that were once considered pejorative or derogatory, such as queer, have now been reclaimed by the LGBT community. These terms may still be associated with a negative connotation for older adults who were raised at a time when these words were used disparagingly. Furthermore, more current terminology such as cis gender, nonbinary, gender queer, and gender fluid, may not be terms that older LGBT adults are accustomed to using. It is best to use terms that a client uses. Listen carefully to clients and incorporate the same words or terms they use when speaking (Lecompte et al., 2020). Be mindful of using gender neutral terms to avoid misgendering someone or making inappropriate assumptions. If a mistake is made when speaking with a client, acknowledge the mistake, apologize, and reassure the client that efforts will be made to avoid repeating the same issue moving forward.

Building Trust and Becoming an Ally

Given that many older LGBT adults may have had negative experiences with health care providers or systems, case managers need to build and foster a trusting relationship (Burton et al., 2020). The case manager often serves as the liaison and advocate for clients. Developing a trusting relationship may take time. Ensuring that one respects and represents a client for who they are as an individual is paramount. Ways to build that trust include not only using inclusive language but also through visible displays of LGBT allyship. This can take on the form of having a rainbow flag, sign, or pin visible in an office, clinic space, or name badge. This may seem like a small gesture, but it is not unusual for

It is important to ask clients how they wish to be called or what name they prefer. Especially for transgender individuals, the name and gender on health insurance or medical records may differ from the client's current identity.

members of the LGBT community to look for these signs of inclusivity. These symbols convey the message that they are in a safe space or speaking to someone who is welcoming. Having these symbols visible can help open the door to conversations that may not otherwise happen.

Navigating Resources

When identifying resources, such as social services, community-based home health services, medical specialists, or other resources, make sure that these services or providers are welcoming and knowledgeable of the needs of LGBT clients (National Resource Center on LGBT Aging, 2020). The LGBTQ+ Healthcare Directory is one example of a resource that offers a list of providers who welcome and are familiar with the care of LGBT clients. Partnering with local LGBT organizations can also be a resource for services within a specific community. This may be more challenging in areas where resources are limited, but through novel strategies (such as telemedicine, social media message boards, or professional networks), it has become easier to connect clients with appropriate resources.

The Human Rights Campaign (HRC) annually publishes the health equality index (https://www.hrc.org/resources/healthcare-equality-index). This index grades and ranks organizations that have demonstrated support for creating inclusive environments for LGBT individuals. Similarly, the HRC has developed the long-term care equality index, which ranks and reviews long-term care facilities that are inclusive and promote equitable treatment of LGBT persons.

Assessment of Social Support, Caregiving

Given that LGBT older adults are more vulnerable to isolation and may lack social support, case managers must prioritize assessing a client's social support network to ensure they have resources or networks that can support them as needed. Also document who a client identifies as a designated family member or proxy to avoid issues that may arise in terms of visitation rights and advanced care planning.

Assessment of financial status, as well as food and housing security, is also important. Because older LGBT adults may be more prone to living near or below the FPL, identifying appropriate support or assisting these are beneficial. Given that a higher proportion of older LGBT adults may live alone, challenges or signs of cognitive impairment may go unrecognized longer than if someone had a partner or family member living with them (Hsieh, et al., 2021). One of the earliest signs of cognitive changes may be evident in the inability to perform instrumental activities of daily living (IADLs) such as managing finances. Therefore, a case manager may be one of the first people to recognize or detect these changes in cognition.

Advanced Care Planning

Advanced care planning and having a designated medical decision-maker are important for all individuals regardless of sexual orientation or gender identity. For LGBT individuals, recognize there are some unique issues that case managers should know: for example, fear of discrimination from health care providers and concerns that end-of-life decisions will not be followed because of potential conflicts between a patient's biological family (who they may be estranged from) and their identified chosen family. For those who may have a same sex partner but who are not married, there is the potential that their partner may be excluded from participating in the medical decision-making process.

A recent study of LGBT adults and advanced care planning identified aspects of care that transgender individuals may face. For example, some study participants felt that having access to gender-affirming hormone therapy was a priority at end-of-life because they wanted to be remembered as the person who they felt was their genuine self (Reich et al., 2022).

When working with clients and discussing advanced care planning, case managers can help to identify clients' identities, document who they wish to be included in medical decision-making, and share client's preferences with their medical team. Other advanced care issues that a case manager can help clients determine and document the names or pronouns they wish to be used in their obituary or on their grave maker. Additionally, details of how a person wishes to be dressed or appear at their funeral are especially important for transgender or gender-nonconforming individuals (Sage, 2024).

The case manager often serves as the liaison and advocate for clients. Developing a trusting relationship may take time.

Health Promotion and Wellness

As the prevalence of multiple chronic conditions increases, health promotion and prevention can help maintain or improve an individual's health status. With the higher prevalence of certain chronic comorbidities, such as heart disease, HIV, and cancer, case managers can play a vital role in the prevention and early detection of these conditions. Ensuring that patients keep and maintain their primary care and specialist appointments, getting recommended vaccinations and cancer screenings, and assessing for mental health conditions, such as depression or anxiety, are key.

For transgender patients, having a body organ inventory is important to ensure that they are receiving appropriate screenings. As an example, a patient who was assigned male at birth (AMAB), but who is now on gender-affirming hormone therapy with estrogen, may still have a prostate and is at risk for prostate cancer. Similarly, someone who is female assigned at birth, but is now on testosterone for masculinizing hormone therapy, may still have a cervix and uterus. Such an individual is still at risk for cervical, uterine, or ovarian cancer and needs appropriate screening. Awareness of these issues is important so that clients receive the appropriate type of care. Some patients may be reluctant to disclose this information with health care professionals. Case managers may be the only person who is aware of these issues, and they should advocate and support clients appropriately. Although health promotion and wellness are important for all individuals regardless of sexual orientation or gender identity, engaging individuals who may have had negative experiences with the health care system is a key component to successful, quality care and interventions.

Conclusion

As the number of older LGBT adults continues to grow, our health care system and the health care workforce need to be prepared to provide quality care to these individuals. The recommendations presented in this article are not meant to be exhaustive. Rather, these foundational steps and interventions provide the first step in assisting case managers learn the skills needed to be better prepared when working with older LGBT clients. Creating a safe, trusting relationship between client and case manager may be the only relationship that some older LGBT adults have in their lives. Table 1 provides a summary of resources that may be beneficial for case managers to use for additional training and resources. Case managers are vital members of the health care team. As a central coordinator of care for older LGBT adults, the contributions and actions case managers provide can improve the quality of care and health outcomes for a growing population. CE II

TABLE 1

EDUCATIONAL RESOURCES TO IMPROVE CARE FOR OLDER LGBT ADULTS

Hope SNF LGBTQ+ Resources
https://phmo.dukehealth.org/HOPE/LITE

LGBTQ + Health Directory
https://lgbtqhealthcaredirectory.org/

National LGBTQIA+ Health Education Center
https://www.lgbtqiahealtheducation.org/

National Resource Center on LGBTQ+ Aging
https://www.lgbtagingcenter.org/

Sagecare LGBTQ+ Aging Cultural Competency
https://sageusa.care/our-services/coaching-training/

Substance Abuse and Mental Health Administration LGBT Training Curriculum for Behavioral Health and Primary Care Practitioners
https://www.samhsa.gov/behavioral-health-equity/lgbtqi/curricula

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Depression and Dementia: Understanding and Responding to Depression in Persons Living with Dementia and their Care Partners

By Denise Scruggs, BSW, MS, MA, CDP, CADDCT, CMDCP, CMDCPT, CDSGF; and Robin Walters, LPN, CDP, CADCT, CMDCP, CMDCPT, CDSGF, APC, CPHCP

Introduction

Dementia and depression are two conditions that significantly affect the mental health and well-being of millions worldwide. Furthermore, they are interconnected in ways care managers need to understand to provide appropriate care interventions that address the complex needs of the person living with dementia and their care partners when either or both also suffer from depression.

Dementia is a group of symptoms caused by various diseases that progressively damage the brain, leading to cognitive loss and changes in memory, language, problem-solving, mood, emotional control, behavior, social abilities, and motivation.[1] Dementia interferes with a person's ability to function independently and perform everyday activities. This leads to dependency on others.

Alzheimer's disease, the most common type of dementia, is estimated to cause 60% to 80% of all cases.[2] Although there is no cure for Alzheimer's disease and other related dementias, there are treatments for Alzheimer's disease that may change the disease progress.[3]

Dementia can take a toll on health and lead to depression in both the person living with dementia and their care partner because it impacts well-being, emotional health, and quality of life for both.

Dementia Prevalence

According to the World Health Organization (WHO), more than 55 million persons worldwide live with dementia, with nearly 10 million new cases diagnosed annually.[4,5] The number of persons diagnosed with dementia is expected to almost triple to more than 152 million by 2050[6], underscoring the need for effective care and support interventions for persons living with dementia and their informal care partners.

In the US, an estimated 6.9 million Americans aged 65 and older have Alzheimer's disease or related dementias[7]; and 200,000 of these persons are under the age of 65 and diagnosed with younger-onset Alzheimer's.[8] Please note that these numbers are underreported because there are many persons living with dementia who have not sought treatment or been diagnosed.

More than 11 million Americans provide unpaid or informal care for persons living with Alzheimer's disease and related dementias.[9] Most informal dementia care (80%) is provided in the home[10] by partners, spouses, children, other family members, and friends.

Caregiving for dementia patients has many rewarding aspects, but it is an intensive, long-term commitment for most and can take a toll on the care partner's physical and mental health while limiting their ability to take care of themselves.

Care partners provide approximately 92 hours of care monthly.[11] However, the number of hours increase as dementia progresses, the person with dementia's cognitive and physical functioning declines, and care partner responsibilities increase.

Dementia caregiving is not a short-term endeavor, and the duration of caregiving can significantly affect the informal care

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partner. The life expectancy of a person with dementia varies depending on their age and the type of dementia they have, but a person diagnosed with Alzheimer's disease has a typical life expectancy of 8 to 10 years.[12] Likewise, informal care partners typically provide 4 or more years of caregiving support.[13]

Caregiving responsibilities vary based on the type and severity of dementia but can include assisting with bathing, dressing, toileting, dining, transportation, shopping, and medication management. Tasks can include managing legal affairs, performing household chores, providing emotional support, and managing behavioral symptoms, such as aggressive behavior, anxiety, depressed mood, and agitation. They can also include finding support services, arranging for and supervising paid care providers, and managing other health concerns.

Depression Diagnosis and Symptoms

Depression is a common but treatable mood disorder characterized by persistent symptoms of depressed mood or loss of pleasure in life, which lasts for 2 weeks or longer and interferes with daily activities.[14] A person with depression also experiences one or more of the following symptoms: significant appetite and weight changes, fatigue or loss of energy, sleep disturbances, feelings of worthlessness or excessive guilt, slowing of thoughts and physical movement, and reduced ability to think or concentrate.[15] Changes in mood and behavior, such as increased irritability, feelings of restlessness, impulsivity, and isolation, can also occur with depression.[16]

It can be challenging to know when a person with dementia is depressed because many of the symptoms of dementia mimic depression. For example, sleep disturbances, slowing of thoughts, appetite, and weight changes are symptoms of both depression and dementia. In addition, it is often difficult for the person living with dementia to express themselves and their feelings.

However, there are some key differences in the symptoms of depression and dementia in people with dementia. The National Institute of Mental Health has outlined a set of guidelines for diagnosing depression in people also diagnosed with Alzheimer's disease, which places less emphasis on verbal expression and cognitive complaints and more emphasis on irritability and social isolation.[17,18]

Additional ways to differentiate between depression and dementia include mood or emotional state, onset, and progression. Persistent sadness is not a symptom related to dementia, but it is a hallmark symptom of depression. Dementia is progressive and takes years to develop, while symptoms of depression progress more rapidly over weeks and months.[19]

There is no single test or procedure to diagnose depression. Instead, a comprehensive person-centered physical and mental evaluation by medical professionals is needed. At the point when depression is suspected, the care manager should make a referral to primary care providers and mental health professionals as needed, conduct initial stress and depression screenings, offer emotional support, and provide education about depression.

Causes of Depression

The relationship between depression and dementia is complex. Although additional research is needed, it is widely acknowledged that people living with dementia are at risk for depression. According to the Alzheimer's Association, experts estimate that 40% of all people with dementia also suffer from depression, and it is a common occurrence in the early and middle stages of Alzheimer's disease.[20]

Depression has many causes and risk factors. Depression can be triggered by health conditions, genetics, inflammation, stress, cognitive decline, brain changes, negative self-concept, lack of social support, and poor diet.[21] Women are also more than twice as likely as men to experience depression.[22]

Confirmation of a diagnosis of dementia and the dementia journey itself may trigger depression and anxiety.[23] Feelings of fear, sadness, and hopelessness can take a toll on emotional health and lead to depression.[24] Not getting enough quality sleep, grief, loss, and feeling stressed about money, relationships, and the future, along with a history of depression, can also increase the risk for depression.[25,26] In addition, the person with dementia may also lose confidence in themselves and their abilities, not trust their judgment, and experience lowered self-esteem, all of which can take a toll on emotional health.[27]

Dementia care partners experience more stress and depressive symptoms than nondementia care partners and the general population.[28,29,30] Grief and loss, hopelessness, despair,

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anger, and denial are some of the feelings a care partner may experience as dementia impacts someone they are close to and creates many life changes they must adjust to.[31]

Care partners experience significant stress, and this stress increases their risk for depression.[32,33] Silvia Sorensen, PhD, and Yeates Conwell, MD, identified primary and secondary stressors and other exacerbating factors that create care partner stress.[34] According to these researchers, primary stressors include the cognitive and functional ability of the person they are caring for, the presence of dementia behaviors, duration of caregiving, hours of care needed, and the presence of unmet needs.[35] Secondary stressors include financial strain, family conflict, social isolation, decreased opportunity for leisure activities, a change in relationship with the person they are caring for, and work conflicts if they continue to be employed outside the home while providing care.[36]

Exacerbating factors include a lack of knowledge about dementia, the quality of the relationship with the person they are caring for, physical health, and the availability of informal assistance and social, emotional, coping, and financial resources.[37,38]

The presence of dementia behaviors such as day and nighttime wandering, emotional outbursts, and inappropriate behavior have also been linked to increased care partner stress and depression, and these types of behaviors are often exacerbated when the person with dementia experiences depression themselves.[39,40,41]

Decreased social networks and support[42] and social isolation[43,44] can take a toll and increase the risk of depression. Care partners taking care of a spouse versus other relatives and friends are also at a higher risk for depression than those who care for other family members or friends.[45]

Providing physical and medical care, especially medication management, can be stressful and negatively impact a care partner's health.[46,47,48,49] In addition, the care partner is at a higher risk for hospitalizations and emergency room visits when the person they care for needs a higher level of functional assistance, has depression, or experiences behavioral issues.[50,51]

Understanding the risks for and causes of depression can help the care manager identify care interventions and strategies that promote physical and emotional health and overall well-being for both the person living with dementia and their care partner.

Treatment of Depression

Early detection and treatment of depression is essential to enhance quality of life for the person with dementia and their care partner. If left untreated, depression can make it harder to enjoy life and exacerbate dementia symptoms and dementia care.

According to the National Institute of Mental Health, there is no one-size-fits-all treatment for depression, and treatment options may include medications, psychotherapy, brain stimulation therapies, lifestyle changes, and alternative medications.[52] In addition, there are many ways a care manager can help.

The Role of a Dementia Navigator or Trained Dementia Practitioner

Navigating dementia, with or without mental health services, is a complex, challenging, and intimidating journey for persons living with dementia and their care partners. In this context, the presence of a dementia navigator or trained dementia practitioner on the care team can provide a sense of relief and reassurance. Their specialized training and understanding of the care continuum and the impact of dementia can also significantly ease the burden on the person with dementia and their care partner.

Recognizing the need that care partners and persons living with dementia have for additional support and assistance, the Alzheimer's Association, in their *2024 Alzheimer's Disease Facts and Figures Report*, recommended having specially trained dementia care navigators on hand to coach, provide support and care-coordination, and educate.[53] The dementia care navigator would not replace existing medical services but would supplement services by working closely with care partners and persons with dementia.[53]

Although more is needed, research has already demonstrated the benefits of a dementia care coordinator. These benefits for the person living with dementia included a significant improvement in well-being and quality of life[54,55] because there was a decrease in depression, illness, strain, embarrassment, and behavioral symptoms.[56,57] For the care partner, the care coordinator helped lower their risk of depression[58,59] and burden,[60] and addressed unmet needs.[61]

For the person living with dementia who also suffers from depression, suggest Tai Chi,[65] stress management techniques,[66] exercise,[67] and reminiscence therapy[68] that brings back positive memories from the past.

The Care Manager's Role in Addressing Depression

The care manager's vital role in addressing depression includes empowering, supporting, advocating for, and serving as a resource for the care partner and the person with dementia. Care interventions include:

- Embrace empathy, dignity, respect, and compassion when working with clients. Dementia is a devastating, life-changing diagnosis for both the person living with dementia and their care partner. Provide opportunities to share thoughts, feelings, and experiences while offering encouragement and helping identify support systems.
- Involve the person with dementia in decision-making and offer choices.
- Address the needs of the person with dementia and their care partner simultaneously and independently because care outcomes for the person with dementia and the care partner are interdependent.
- Address the emotional and psychological needs of the person with dementia and their care partner and integrate mental health services and interventions in care plans. Refer persons with early-stage dementia and care partners to mental health resources as needed, including online, telephone, and in-person support groups, helplines, grief support, and counseling. Share coping and stress management strategies and techniques such as deep breathing, mindfulness, and exercise to help lower care partner stress.[62,63,64] For the person living with dementia who also suffers from depression, suggest Tai Chi,[65] stress management techniques,[66], exercise,[67] and reminiscence therapy[68] that brings back positive memories from the past.
- Promote early detection and diagnosis of depression. Make it a practice to ask if a person is feeling 'depressed,' and if they report 'yes,' inquire about how long they have had these feelings. If longer than 2 weeks, refer them to a mental health specialist for additional evaluation. Also, conduct routine stress and depression screenings using one of the many tools available, including the Geriatric Depression Scale (GDS)[69] and Cornell Scale for Persons with Cognitive Loss (CSDD),[70] to aid in the early detection of depression, and the American Psychological Association's Caregiver Self-Assessment Questionnaire[71] to identify care partner stress.
- Use a collaborative interdisciplinary approach to provide holistic comprehensive care and develop personalized care plans and interventions.[72] This team can include family members, trained and certified dementia practitioners, care managers, physicians, mental health professionals, social workers, nurses, clergy, physical therapists, speech therapists, occupational therapists, and other care providers.
- Link to community resources that relieve some of the negative aspects of caregiving such as care partner burden and stress and address the unique needs of the person living with dementia. Resources that are helpful include legal and financial planning assistance, respite care, companionship, ADL and IADL assistance, palliative care, hospice, residential care, and medical care.
- Enhance the care partner's knowledge, skills, confidence, and feelings of competency[73] by providing educational materials, computer apps, and online resources about dementia and depression and recommending care partner training programs that equip them with the tools they need to manage depression and dementia behaviors, communicate effectively, and cope with caregiving responsibilities.
- Regularly check in and provide ongoing follow-up with the care partner and the person living with dementia via in-person visits, telephone calls, and online interactions. Offer support, review care outcomes, identify treatment adherence, and stay abreast of needs as dementia progresses and needs change.[74]
- Encourage self-care activities that support overall well-being, including physical activity, socialization, participation in activities that bring enjoyment and meaning, and the creation of a living and care environment that minimizes stress.[75,76,77]
- Be aware of the warning signs of care partner stress. According to the Alzheimer's Society, these signs include denial, anger, social withdrawal, anxiety, depression, exhaustion, lack of concentration, health problems, sleeplessness, and being easily irritated or emotional.[78]

In closing, the care manager is vital to assessing and addressing the complex needs of the care partner and the person with dementia who also suffers from depression or is at risk for depression. If the care manager works in collaboration with a trained dementia professional or dementia care navigator and an interdisciplinary care team, care outcomes can be enhanced. CE 3

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PharmaFacts for Case Managers

OCREVUS ZUNOVOTM (ocrelizumab and hyaluronidase-ocsq) injection, for subcutaneous use

INDICATIONS AND USAGE

OCREVUS ZUNOVO is indicated for the treatment of:

- Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
- Primary progressive MS, in adults

DOSAGE AND ADMINISTRATION

Important Administration Information

OCREVUS ZUNOVO is for subcutaneous use in the abdomen only.

OCREVUS ZUNOVO has different dosage and administration instructions than intravenous ocrelizumab. OCREVUS ZUNOVO should be administered via subcutaneous injection by a healthcare professional.

Assessments Prior to First Dose of OCREVUS ZUNOVO

Hepatitis B Virus Screening

Prior to initiating ocrelizumab treatment, perform Hepatitis B virus (HBV) screening. OCREVUS ZUNOVO is contraindicated in patients with active HBV confirmed by positive results for HBsAg and anti-HBV tests. For patients who are negative for surface antigen [HBsAg] and positive for HB core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consult liver disease experts before starting and during treatment.

Serum Immunoglobulins

Prior to initiating ocrelizumab treatment, perform testing for quantitative serum immunoglobulins. For patients with low serum immunoglobulins, consult immunology experts before initiating treatment with ocrelizumab.

Vaccinations

Because vaccination with live-attenuated or live vaccines is not recommended during treatment and after discontinuation until B-cell repletion, administer all immunizations according to immunization guidelines at least 4 weeks prior to initiation of ocrelizumab treatment for live or live-attenuated vaccines and, whenever possible, at least 2 weeks prior to initiation of ocrelizumab treatment for non-live vaccines.

Assessments and Premedication Prior to Every Dose

Infection Assessment

Prior to every dose of OCREVUS ZUNOVO, determine whether there is an active infection. In case of active infection, delay administration of OCREVUS ZUNOVO until the infection resolves.

Recommended Premedication

Pre-medicate orally with 20 mg of dexamethasone (or an equivalent corticosteroid) and an antihistamine (e.g., desloratadine) administered at least 30 minutes prior to each OCREVUS ZUNOVO administration to reduce the risk of local and systemic injection reactions.

The addition of an antipyretic (e.g., acetaminophen) may also be considered.

Recommended Dosage

The recommended dosage of OCREVUS ZUNOVO is 920 mg/23,000 units (920 mg ocrelizumab and 23,000 units of hyaluronidase) administered as a single 23 mL subcutaneous injection in the abdomen over approximately 10 minutes every 6 months.

Monitor the patient closely during injections, with access to appropriate medical support to manage severe injection reactions. For the initial dose, monitor the patient for at least one hour post-injection. For subsequent doses, monitor the patient for at least 15 minutes post-injection.

Delayed or Missed Doses

If a planned injection of OCREVUS ZUNOVO is missed, administer OCREVUS ZUNOVO as soon as possible; do not wait until the next scheduled dose. Reset the dose schedule to administer the next sequential dose 6 months after the missed dose is administered. Doses of OCREVUS ZUNOVO must be separated by at least 5 months.

DOSAGE FORMS AND STRENGTHS

Injection: 920 mg ocrelizumab and 23,000 units hyaluronidase per 23 mL (40 mg and 1,000 units per mL) clear to slightly opalescent, and colorless to pale brown solution in a single-dose vial.

CONTRAINDICATIONS

OCREVUS ZUNOVO is contraindicated in patients with:

- Active HBV infection

- A history of life-threatening administration reaction to ocrelizumab
- A history of hypersensitivity to ocrelizumab, hyaluronidase, or any component of OCREVUS ZUNOVO

WARNINGS AND PRECAUTIONS

Injection Reactions

OCREVUS ZUNOVO can cause injection reactions, which can be local or systemic. Common symptoms of local injection reactions reported by patients treated with OCREVUS ZUNOVO in multiple sclerosis (MS) clinical trials included erythema, pain, swelling, and pruritus. Common symptoms of systemic injection reactions reported by patients included headache and nausea. In an open-label, active-controlled trial, injection reactions were more frequently reported with the first injection; 49% of patients experienced an injection reaction with the first injection.

In MS clinical trials where ocrelizumab was administered intravenously, the incidence of infusion reactions in patients [who received methylprednisolone (or an equivalent steroid) and possibly other premedication to reduce the risk of infusion reactions prior to infusion] was 34% to 40%, with the highest incidence with the first infusion. There were no fatal infusion reactions, but 0.3% of intravenous ocrelizumab-treated MS patients experienced infusion reactions that were serious, some requiring hospitalization. Symptoms of infusion reactions can include pruritus, rash, urticaria, erythema, bronchospasm, throat irritation, oropharyngeal pain, dyspnea, pharyngeal or laryngeal edema, flushing, hypotension, pyrexia, fatigue, headache, dizziness, nausea, tachycardia, and anaphylaxis.

Monitor patients during and after injections. Inform patients that injection reactions can occur during or within 24 hours of the injection.

Reducing the Risk of Injection Reactions and Managing Injection Reactions

Administer oral premedication (e.g., dexamethasone or an equivalent corticosteroid, and an antihistamine) at least 30 minutes prior to each OCREVUS ZUNOVO injection to reduce the risk of injection reactions. The addition of an antipyretic (e.g., acetaminophen) may also be considered.

Management recommendations for injection reactions depend on the type and severity of the reaction. For life- threatening injection reactions, immediately and permanently stop OCREVUS ZUNOVO and administer appropriate supportive treatment. For less severe injection reactions, the injection should be interrupted immediately, and the patient should receive symptomatic treatment. The injection should be completed at the healthcare provider's discretion and only after all symptoms have resolved.

Infections

Serious, including life-threatening or fatal, bacterial, viral, parasitic, and fungal infections have been reported in patients receiving ocrelizumab. An increased risk of infections (including serious and fatal bacterial, fungal, and new or reactivated viral infections) has been observed in patients during and following completion of treatment with anti-CD20 B-cell depleting therapies.

A higher proportion of intravenous ocrelizumab-treated patients experienced infections compared to patients taking REBIF or placebo. In RMS trials, 58% of intravenous ocrelizumab-treated patients experienced one or more infections compared to 52% of REBIF-treated patients. In the PPMS trial, 70% of intravenous ocrelizumab-treated patients experienced one or more infections compared to 68% of patients on placebo.

Intravenous ocrelizumab was not associated with an increased risk of serious infections in MS patients in controlled trials.

Ocrelizumab increases the risk for upper respiratory tract infections, lower respiratory tract infections, skin infections, and herpes-related infections.

Delay OCREVUS ZUNOVO administration in patients with an active infection until the infection is resolved.

Respiratory Tract Infections

A higher proportion of intravenous ocrelizumab-treated patients experienced respiratory tract infections compared to patients taking REBIF or placebo. In RMS trials, 40% of patients treated with intravenous ocrelizumab experienced upper respiratory tract infections compared to 33% of REBIF-treated patients, and 8% of patients treated with intravenous ocrelizumab experienced lower respiratory tract infections compared to 5% of REBIF- treated patients. In the PPMS trial, 49% of patients treated with intravenous ocrelizumab experienced upper respiratory tract infections compared to 43% of patients on placebo, and 10% of patients treated with intravenous ocrelizumab experienced lower respiratory tract infections compared to 9% of patients on placebo. The infections were predominantly mild to moderate and consisted mostly of upper respiratory tract infections and bronchitis.

Herpes

In active-controlled (RMS) clinical trials, herpes infections were reported more frequently in patients treated with intravenous ocrelizumab than in REBIF-treated patients, including herpes zoster (2.1% vs. 1.0%), herpes simplex (0.7% vs. 0.1%), oral herpes (3.0% vs. 2.2%), genital herpes (0.1% vs. 0%), and herpes virus infection (0.1% vs. 0%). Infections were predominantly mild to moderate in severity.

In the placebo-controlled (PPMS) clinical trial, oral herpes was reported more frequently in the patients treated with intravenous ocrelizumab than in the patients on placebo (2.7% vs. 0.8%).

Serious cases of infections caused by herpes simplex virus and varicella zoster virus, including central nervous system infections (encephalitis and meningitis), intraocular infections, and disseminated skin and soft tissue infections, have been reported in the postmarketing setting in multiple sclerosis patients receiving ocrelizumab. Some cases were life-threatening. Serious herpes virus infections may occur at any time during treatment with OCREVUS ZUNOVO.

If serious herpes infections occur, OCREVUS ZUNOVO should be discontinued or withheld until the infection has resolved, and appropriate treatment should be administered [see Patient Counseling Information (17)].

Hepatitis B Virus Reactivation

Hepatitis B virus (HBV) reactivation has been reported in MS patients treated with ocrelizumab in the postmarketing setting. Fulminant hepatitis, hepatic failure, and death caused by HBV reactivation have occurred in patients treated with anti-CD20 antibodies. Perform HBV screening in all patients before initiation of treatment with ocrelizumab. Do not administer OCREVUS ZUNOVO to patients with active HBV confirmed by positive results for HBsAg and anti-HB tests. For patients who are negative for surface antigen [HBsAg] and positive for HB core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consult liver disease experts before starting and during treatment.

Possible Increased Risk of Immunosuppressant Effects With Other Immunosuppressants

When initiating OCREVUS ZUNOVO after an immunosuppressive therapy or initiating an immunosuppressive therapy after OCREVUS ZUNOVO, consider the potential for increased immunosuppressive effects. OCREVUS ZUNOVO has not been studied in combination with other MS therapies.

Vaccinations

Administer all immunizations according to immunization guidelines at least 4 weeks prior to initiation of ocrelizumab treatment for live or live-attenuated vaccines and, whenever possible, at least 2 weeks prior to initiation of ocrelizumab for non-live vaccines.

OCREVUS ZUNOVO may interfere with the effectiveness of non-live vaccines.

The safety of immunization with live or live-attenuated vaccines following OCREVUS ZUNOVO therapy has not been studied, and vaccination with live-attenuated or live vaccines is not recommended during treatment and until B-cell repletion.

- *Vaccination of Infants Born to Mothers Treated with OCREVUS ZUNOVO During Pregnancy*

In infants of mothers exposed to OCREVUS ZUNOVO during pregnancy, do not administer live or live- attenuated vaccines before confirming the recovery of B-cell counts as measured by CD19+ B-cells. Depletion of B-cells in these infants may increase the risks from live or live-attenuated vaccines.

You may administer non-live vaccines, as indicated, prior to recovery from B-cell depletion, but should consider assessing vaccine immune responses, including consultation with a qualified specialist, to assess whether a protective immune response was mounted.

Progressive Multifocal Leukoencephalopathy

Cases of progressive multifocal leukoencephalopathy (PML) have been reported in patients with MS treated with ocrelizumab in the postmarketing setting. PML is an opportunistic viral infection of the brain caused by the JC virus (JCV) that typically only occurs in patients who are immunocompromised, and that usually leads to death or severe disability. PML has occurred in ocrelizumab-treated patients who had not been treated previously with natalizumab (which has a known association with PML), were not taking any immunosuppressive or immunomodulatory medications associated with the risk of PML prior to or concomitantly with ocrelizumab, and did not have any known ongoing systemic medical conditions resulting in compromised immune system function.

JCV infection resulting in PML has also been observed in patients treated with other anti-CD20 antibodies and other MS therapies.

At the first sign or symptom suggestive of PML, withhold OCREVUS ZUNOVO and perform an appropriate diagnostic evaluation. Typical symptoms associated with PML are diverse, progress over days to weeks, and include progressive weakness on one side of the body or clumsiness of limbs, disturbance of vision, and changes in thinking, memory, and orientation leading to confusion and personality changes.

MRI findings may be apparent before clinical signs or symptoms. Cases of PML, diagnosed based on MRI findings and the detection of JCV DNA in the cerebrospinal fluid in the absence of clinical signs or symptoms specific to PML, have been reported in patients treated with other MS medications associated with PML. Many of these patients subsequently became symptomatic with PML. Therefore, monitoring with MRI for signs that may be consistent with PML may be useful, and any suspicious findings should lead to further investigation to allow for an early diagnosis of PML, if present. Following discontinuation of another MS medication associated with PML, lower PML-related mortality and morbidity have been reported in patients who were initially asymptomatic at diagnosis compared to patients who had characteristic clinical signs and symptoms at diagnosis.

It is not known whether these differences are due to early detection and discontinuation of MS treatment or due to differences in disease in these patients.

If PML is confirmed, treatment with OCREVUS ZUNOVO should be discontinued.

Reduction in Immunoglobulins

As expected with any B-cell depleting therapy, decreased immunoglobulin levels are observed with ocrelizumab treatment. The pooled data of intravenous ocrelizumab clinical studies (RMS and PPMS) and their open-label extensions (up to approximately 7 years of exposure) have shown an association between decreased levels of immunoglobulin G (IgG<LLN) and increased rates of serious infections. Monitor the levels of quantitative serum immunoglobulins during OCREVUS ZUNOVO treatment and after discontinuation of treatment, until B-cell repletion, and especially in the setting of recurrent serious infections. Consider discontinuing OCREVUS ZUNOVO therapy in patients with serious opportunistic or recurrent serious infections, and if prolonged hypogammaglobulinemia requires treatment with intravenous immunoglobulins.

Malignancies

An increased risk of malignancy with OCREVUS ZUNOVO may exist. In controlled trials, malignancies, including breast cancer, occurred more frequently in patients treated with intravenous ocrelizumab. Breast cancer occurred in 6 of 781 females treated with intravenous ocrelizumab and none of 668 females treated with REBIF or placebo. Patients should follow standard breast cancer screening guidelines.

Immune-Mediated Colitis

Immune-mediated colitis, which can present as a severe and acute-onset form of colitis, has been reported in patients receiving ocrelizumab in the postmarketing setting. Some cases of colitis were serious, requiring hospitalization, with a few patients requiring surgical intervention. Systemic corticosteroids were required in many of these patients. The time from treatment initiation to onset of symptoms in these cases ranged from a few weeks to years. Monitor patients for immune-mediated colitis during OCREVUS ZUNOVO treatment, and evaluate promptly if signs and symptoms that may indicate immune-mediated colitis, such as new or persistent diarrhea or other gastrointestinal signs and symptoms, occur.

Adverse Reactions

The most common adverse reactions in RMS trials (incidence ≥ 10%) were upper respiratory tract infections and infusion reactions.

DRUG INTERACTIONS

Immunosuppressive or Immune-Modulating Therapies

The concomitant use of OCREVUS ZUNOVO and other immune-modulating or immunosuppressive therapies, including immunosuppressant doses of corticosteroids, is expected to increase the risk of immunosuppression. Consider the risk of additive immune system effects when coadministering immunosuppressive therapies with OCREVUS ZUNOVO. When switching from drugs with prolonged immune effects, such as daclizumab, fingolimod, natalizumab, teriflunomide, or mitoxantrone, consider the duration and mode of action of these drugs because of additive immunosuppressive effects when initiating OCREVUS ZUNOVO.

Vaccinations

A Phase 3b randomized, open-label study examined the concomitant use of intravenous ocrelizumab and several non-live vaccines in adults 18-55 years of age with relapsing forms of MS (68 subjects undergoing treatment with intravenous ocrelizumab at the time of vaccination and 34 subjects not undergoing treatment with intravenous ocrelizumab at the time of vaccination). Concomitant exposure to intravenous ocrelizumab attenuated antibody responses to tetanus toxoid-containing vaccine, pneumococcal polysaccharide, pneumococcal conjugate vaccines, and seasonal inactivated influenza vaccines. The impact of the observed attenuation on vaccine effectiveness in this patient population is unknown. The safety and effectiveness of live or live-attenuated vaccines administered concomitantly with ocrelizumab have not been assessed,

CLINICAL STUDIES

Studies 1-3 (described below), which established the effectiveness of ocrelizumab for the treatment of RMS and PPMS in adults, were conducted with intravenously-administered ocrelizumab. Study 4 demonstrated comparable exposure of OCREVUS ZUNOVO relative to the ocrelizumab intravenous formulation, which established the efficacy of OCREVUS ZUNOVO.

Intravenous Ocrelizumab in Patients With Relapsing Forms of Multiple Sclerosis

The efficacy of intravenous ocrelizumab was demonstrated in two randomized, double-blind, double-dummy, active comparator-controlled clinical trials of identical design, in patients with relapsing forms of multiple sclerosis (RMS) treated for 96 weeks (Study 1; NCT01247324 and Study 2; NCT01412333). The dose of intravenous ocrelizumab was 600 mg every 24 weeks (initial treatment was given as two 300 mg IV infusions administered 2 weeks apart, and subsequent doses were administered as a single 600 mg IV infusion) and placebo subcutaneous injections were given 3 times per week. The dose of REBIF, the active comparator, was 44 mcg given as subcutaneous injections 3 times per week and placebo IV infusions were given every 24 weeks. Both studies included patients who had experienced at least one relapse within the prior year, or two relapses within the prior two years, and had an Expanded Disability Status Scale (EDSS) score from 0 to 5.5. Patients with primary progressive forms of multiple sclerosis (MS) were excluded. Neurological evaluations were performed every 12 weeks and at the time of a suspected relapse. Brain MRIs were performed at baseline and at Weeks 24, 48, and 96.

The primary outcome of both Study 1 and Study 2 was the annualized relapse rate (ARR). Additional outcome measures included the proportion of patients with confirmed disability progression, the mean number of MRI T1 gadolinium (Gd)-enhancing lesions at Weeks 24, 48, and 96, and new or enlarging MRI T2 hyperintense lesions. Progression of disability was defined as an increase of 1 point or more from the baseline

EDSS score attributable to MS when the baseline EDSS score was 5.5 or less, or 0.5 points or more when the baseline EDSS score was above 5.5. Disability progression was considered confirmed when the increase in the EDSS was confirmed at a regularly scheduled visit 12 weeks after the initial documentation of neurological worsening. The primary population for analysis of confirmed disability progression was the pooled population from Studies 1 and 2.

In Study 1, 410 patients were randomized to intravenous ocrelizumab and 411 to REBIF; 11% of intravenous ocrelizumab-treated patients and 17% of REBIF-treated patients did not complete the 96-week double-blind treatment period. The baseline demographic and disease characteristics were balanced between the two treatment groups. At baseline, the mean age of patients was 37 years; 66% were female. The mean time from MS diagnosis to randomization was 3.8 years, the mean number of relapses in the previous year was 1.3, and the mean EDSS score was 2.8; 74% of patients had not been treated with a non-steroid therapy for MS in the 2 years prior to the study. At baseline, 40% of patients had one or more T1 Gd-enhancing lesions (mean 1.8).

In Study 2, 417 patients were randomized to intravenous ocrelizumab and 418 to REBIF; 14% of intravenous ocrelizumab-treated patients and 23% of REBIF-treated patients did not complete the 96-week double-blind treatment period. The baseline demographic and disease characteristics were balanced between the two treatment groups. At baseline, the mean age of patients was 37 years; 66% were female. The mean time from MS diagnosis to randomization was 4.1 years, the mean number of relapses in the previous year was 1.3, and the mean EDSS score was 2.8; 74% of patients had not been treated with a non-steroid therapy for MS in the 2 years prior to the study. At baseline, 40% of intravenous ocrelizumab-treated patients had one or more T1 Gd-enhancing lesions (mean 1.9).

In Study 1 and Study 2, intravenous ocrelizumab significantly lowered the annualized relapse rate and the proportion of patients with disability progression confirmed at 12 weeks after onset compared to REBIF

Intravenous Ocrelizumab in Patients With Primary Progressive Multiple Sclerosis

Study 3 was a randomized, double-blind, placebo-controlled clinical trial in patients with primary progressive multiple sclerosis (PPMS) (NCT01194570). Patients were randomized 2:1 to receive either intravenous ocrelizumab 600 mg or placebo as two 300 mg intravenous infusions 2 weeks apart every 24 weeks for at least 120 weeks. Selection criteria required a baseline EDSS of 3 to 6.5 and a score of 2 or greater for the EDSS pyramidal functional system due to lower extremity findings. Neurological assessments were conducted every 12 weeks. An MRI scan was obtained at baseline and at Weeks 24, 48, and 120.

In Study 3, the primary outcome was the time to onset of disability progression attributable to MS confirmed to be present at the next neurological assessment at least 12 weeks later. Disability progression occurred when the EDSS score increased by 1 point or more from the baseline EDSS if the baseline EDSS was 5.5 points or less, or by 0.5 points or more if the baseline EDSS was more than 5.5 points. In Study 3, confirmed disability progression also was deemed to have occurred if patients who had onset of disability progression discontinued participation in the study before the next assessment. Additional outcome measures included timed 25-foot walk, and percentage change in T2 hyperintense lesion volume.

Study 3 randomized 488 patients to intravenous ocrelizumab and 244 to placebo; 21% of intravenous ocrelizumab-treated patients and 34% of placebo-treated patients did not complete the trial. The baseline demographic and disease characteristics were balanced between the two treatment groups. At baseline, the mean age of patients was 45; 49% were female. The mean time since symptom onset was 6.7 years, the mean EDSS score was 4.7, and 26% had one or more T1 Gd-enhancing lesions at baseline; 88% of patients had not been treated previously with a non-steroid treatment for MS. The time to onset of disability progression confirmed a 12 weeks after onset was significantly longer for intravenous ocrelizumab-treated patients than for placebo-treated patients.

In the overall population in Study 3, the proportion of patients with 20 percent worsening of the timed 25-foot walk confirmed at 12 weeks was 49% in intravenous ocrelizumab-treated patients compared to 59% in placebo- treated patients (25% risk reduction).

In exploratory subgroup analyses of Study 3, the proportion of female patients with disability progression confirmed at 12 weeks after onset was similar in intravenous ocrelizumab-treated patients and placebo-treated patients (approximately 36% in each group). In male patients, the proportion of patients with disability progression confirmed at 12 weeks after onset was approximately 30% in intravenous ocrelizumab-treated patients and 43% in placebo-treated patients. Clinical and MRI endpoints that generally favored intravenous ocrelizumab numerically in the overall population, and that showed similar trends in both male and female patients, included annualized relapse rate, change in T2 lesion volume, and number of new or enlarging T2 lesions.

OCREVUS ZUNOVO in Patients With RMS or PPMS

Study 4 was a multicenter, randomized, open-label, parallel arm trial conducted to evaluate the comparative bioavailability, pharmacokinetics, pharmacodynamics, safety, and immunogenicity of OCREVUS ZUNOVO compared with intravenous ocrelizumab in patients with either RMS or PPMS (NCT05232825).

Study 4 enrolled 236 patients (213 with RMS, 23 with PPMS),

continues on page 34

LITSCAN
FOR CASE MANAGERS

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

AIDS. 2024 Sep 2. doi: 10.1097/QAD.0000000000004002. Online ahead of print.

Primary HPV screening compared with other cervical cancer screening strategies in women with HIV: a cost-effectiveness study

Ran Zhao, Erinn Sanstead, Fernando Alarid-Escudero, et al.

OBJECTIVE: To compare the model-predicted benefits, harms, and cost-effectiveness of cytology, cotesting, and primary HPV screening in U.S. women living with HIV (WLWH).

DESIGN: We adapted a previously published Markov decision model to simulate a cohort of U.S. WLWH.

SETTING: United States.

SUBJECTS, PARTICIPANTS: A hypothetical inception cohort of WLWH.

INTERVENTION: We simulated five screening strategies all assumed the same strategy of cytology with HPV triage for ASCUS for women aged 21 to 29 years. The different strategies noted are for women aged 30 and older as the following: continue cytology with HPV triage, cotesting with repeat cotesting triage, cotesting with HPV16/18 genotyping triage, primary hrHPV testing with cytology triage, and primary hrHPV testing with HPV16/18 genotyping triage.

MAIN OUTCOME MEASURES: The outcomes include colposcopies, false-positive results, treatments, cancers, cancer deaths, life-years and costs, and lifetime quality-adjusted life-years.

RESULTS: Compared with no screening, screening was cost-saving, and > 96% of cervical cancers and deaths could be prevented. Cytology with HPV triage dominated primary HPV screening and cotesting. At willingness-to-pay thresholds under $250,000, probabilistic sensitivity analyses indicated that primary HPV testing was more cost-effective than cotesting in over 98% of the iterations.

CONCLUSIONS: Our study suggests the current cytology-based screening recommendation is cost-effective, but that primary HPV screening could be a cost-effective alternative to cotesting. To improve the cost-effectiveness of HPV-based screening, increased acceptance of the HPV test among targeted women is needed, as are alternative follow-up recommendations to limit the harms of high false-positive testing.

J Am Coll Cardiol. 2024 Aug 29:S0735-1097(24)08192-0. doi: 10.1016/j.jacc.2024.08.021. Online ahead of print.

Effect of semaglutide on cardiac structure and function in patients with obesity-related heart failure

Scott D Solomon, John W Ostrominski, Xiaowen Wang, et al.; STEP-HFpEF Trial Committees and Investigators

BACKGROUND: Obesity is associated with adverse cardiac remodeling and is a key driver for the development and progression of heart failure (HF). Once-weekly semaglutide (2.4 mg) has been shown to improve HF-related symptoms and physical limitations, body weight, and exercise function in patients with obesity-related heart failure with preserved ejection fraction (HFpEF), but the effects of semaglutide on cardiac structure and function in this population remain unknown.

OBJECTIVEs: In this echocardiography substudy of the STEP-HFpEF Program, we evaluated treatment effects of once-weekly semaglutide (2.4 mg) vs placebo on cardiac structure and function.

METHODS: Echocardiography at randomization and 52 weeks was performed in 491 of 1,145 participants (43%) in the STEP-HFpEF Program (pooled STEP-HFpEF [Semaglutide Treatment Effect in People with Obesity and HFpEF] and STEP-HFpEF DM [Semaglutide Treatment Effect in People with Obesity, HFpEF, and Type 2 Diabetes] trials). The prespecified primary outcome was change in left atrial (LA) volume, with changes in other echocardiography parameters evaluated as secondary outcomes. Treatment effects of semaglutide vs placebo were assessed using analysis of covariance stratified by trial and body mass index, with adjustment for baseline parameter values.

RESULTS: Overall, baseline clinical and echocardiographic characteristics were balanced among those receiving semaglutide (n = 253) and placebo (n = 238). Between baseline and 52 weeks, semaglutide attenuated progression of LA remodeling (estimated mean difference [EMD] in LA volume, -6.13 mL; 95% CI: -9.85 to -2.41 mL; P = 0.0013) and right ventricular (RV) enlargement (EMD in RV end-diastolic area: -1.99 cm2; 95% CI: -3.60 to -0.38 cm2; P = 0.016; EMD in RV end-systolic area: -1.41 cm2; 95% CI: -2.42 to -0.40] cm2; P = 0.0064) compared with placebo.

Semaglutide additionally improved E-wave velocity (EMD: -5.63 cm/s; 95% CI: -9.42 to -1.84 cm/s; P = 0.0037), E/A (early/late mitral inflow velocity) ratio (EMD: -0.14; 95% CI: -0.24 to -0.04; P = 0.0075), and E/e’ (early mitral inflow velocity/early diastolic mitral annular velocity) average (EMD: -0.79; 95% CI: -1.60 to 0.01; P = 0.05). These associations were not modified by diabetes or atrial fibrillation status. Semaglutide did not significantly affect left ventricular dimensions, mass, or systolic function. Greater weight loss with semaglutide was associated with greater reduction in LA volume (Pinteraction = 0.033) but not with changes in E-wave velocity, E/e› average, or RV end-diastolic area.

CONCLUSIONS: In the STEP-HFpEF Program echocardiography substudy, semaglutide appeared to improve adverse cardiac remodeling compared with placebo, further suggesting that treatment with semaglutide may be disease modifying among patients with obesity-related HFpEF. (Research Study to Investigate How Well Semaglutide Works in People Living With Heart Failure and Obesity [STEP-HFpEF]; NCT04788511; Research Study to Look at How Well Semaglutide Works in People Living With Heart Failure, Obesity and Type 2 Diabetes [STEP-HFpEF DM]; NCT04916470).

AIDS. 2024 Sep 4.doi: 10.1097/QAD.0000000000004006. Online ahead of print.

Low food security is associated with frailty status and frailty components among people with HIV

Stephanie A Ruderman, Amanda L Willig, John D Cleveland, et al.

BACKGROUND: Low food security is common among people with HIV (PWH) and is associated with poorer health outcomes. Frailty, an aging-related outcome that is increasingly prevalent among PWH, may be stimulated by low food security. We assessed associations between food security and frailty among PWH.

METHODS: The Impact of Physical Activity Routines and Dietary Intake on the Longitudinal Symptom Experience of People Living with HIV (PROSPER-HIV) study follows PWH to evaluate how diet and physical activity impact symptoms. We utilized food security and frailty data from PROSPER-HIV Year 1 visits (January 2019 to July 2022) to estimate associations. Food security was measured via the validated two-item Food Security Questionnaire and categorized as Food Secure, Low Food Security, or Very Low Food Security. Frailty was measured with the Fried frailty phenotype, and categorized as robust, prefrail, and frail. We used relative risk regression to estimate associations between food security and frailty status, adjusted for demographic characteristics.

RESULTS: Among 574 PWH, nearly one-quarter were women (22%), mean age was 52 years old, 8% were frail, and 46% prefrail. Low food security was reported among nearly one-third of PWH: 13% Low Food Security and 18% Very Low Food Security. Compared with being Food Secure, we found Low Food Security was associated with frailty [prevalence ratio: 4.06 (95% confidence interval (CI) 2.16-7.62] and Very Low Food Security was associated with both prefrailty [1.48 (1.23-1.78)] and frailty [5.61 (3.14-10.0)], as compared with robust status.

CONCLUSION: Low food security was associated with increased frailty among PWH in this study, suggesting a potential intervention point to promote healthy aging.

Eur J Heart Fail. 2024 Sep 3. doi: 10.1002/ejhf.3447. Online ahead of print.

Metabolic dysfunction and incidence of heart failure subtypes among Black individuals: the Jackson Heart Study

Arnaud D Kaze, Alain G Bertoni, Ervin R Fox, et al.

AIMS: The extent to which metabolic syndrome (MetS) severity influences subclinical myocardial remodelling, heart failure (HF) incidence and subtypes, remains unclear. We assessed the association of MetS with incident HF (including ejection fraction subtypes) among Black individuals.

METHODS AND RESULTS: We included 4069 Jackson Heart Study participants (mean age 54.4 years, 63.8% women, 37.2% with MetS) without HF. We categorized participants based on MetS status and MetS severity scores (based on waist circumference [MetS-Z-WC] and body mass index [MetS-Z-BMI]). We assessed the associations of MetS indices with echocardiographic parameters, biomarkers of myocardial damage (high-sensitivity cardiac troponin I [hs-cTnI] and B-type natriuretic peptide [BNP]) and incident HF hospitalizations including HF with preserved ejection fraction (HFpEF) and HF with reduced ejection fraction (HFrEF). MetS severity was associated with subclinical cardiac remodelling (assessed by echocardiographic measures and biomarkers of myocardial damage). Over a median of 12 years, 319 participants developed HF (157 HFpEF, 149 HFrEF and 13 HF of unknown type). MetS was associated with a twofold greater risk of HF (hazard ratio [HR] 2.07, 95% confidence interval [CI] 1.64-2.61). Compared to the lowest quartile (Q1) of MetS-Z-WC, the highest quartile (Q4) conferred a higher risk of HF (HR 2.35, 95% CI 1.67-3.30), with a stronger association for HFpEF (Q4 vs. Q1: HR 4.94, 95% CI 2.67-9.14) vs. HFrEF (HR 1.69, 95% CI 1.06-2.70).

CONCLUSIONS: Metabolic syndrome severity was associated with both HF subtypes among Black individuals, highlighting the importance of optimal metabolic health for preventing HF.

Am J Epidemiol. 2024 Sep 3:kwae341. doi: 10.1093/aje/kwae341. Online ahead of print.

Comparing two-step approaches to measuring gender identity: the reliability and applications of asking about sex assigned at birth versus transgender self-identification

Diana M Tordoff, Brian Minalga, Nicole Ó Catháin, et al.; Seattle Trans and Nonbinary Sexual Health (STARS) Advisory Board

Inclusive measures of gender are critical for health equity research. This study compared the reliability and applications of two different approaches for measuring gender in response to emerging community concerns regarding the potential harms of asking about sex assigned at birth (SAAB) within transgender and gender diverse (TGD) populations. Using data from a 2021 survey of LGBTQ+ people in Washington state, we compared approaches for measuring gender via a two-step question that collected data on: (1) current gender and SAAB versus (2) current gender and transgender self-identification. Among 2,275 LGBTQ+ participants aged 9-81, 63% were cisgender, 35% TGD, and 2% were not categorized. There was near perfect agreement between the two methods in their ability to identify TGD participants (percent agreement=99.7%, unweighted Cohen's Kappa=0.99). Among gender diverse participants, SAAB revealed differences in sexual health outcomes, while stratification by transgender self-identification revealed differences in access to gender-affirming care and lifetime experiences of discrimination. Ascertaining SAAB may be most useful for identifying sexual health disparities while transgender self-identification may better illuminate healthcare needs and social determinants of health among TGD people. Researchers and public health practitioners should critically consider the acceptability and relevance of SAAB questions to their research goals.

Hypertension. 2024 Sep 4. doi: 10.1161/HYPERTENSIONAHA.124.20533. Online ahead of print.

Achieving equity in hypertension: a review of current efforts by the American Heart Association

Shakia T Hardy, Valy Fontil, Glenn H Dillon, Daichi Shimbo

The purpose of this article is to summarize disparities in blood pressure (BP) by race in the United States, discuss evidence-based strategies to increase equity in BP, review recent American Heart Association BP equity initiatives, and highlight missed opportunities for achieving equity in hypertension. Over 122 million American adults have hypertension, with the highest prevalence among Black Americans. Racial disparities in hypertension and BP control in the United States are estimated to be the single largest contributor to the excess risk for cardiovascular disease among Black versus White adults. Worsening disparities in cardiovascular disease and life expectancy during the COVID-19 pandemic warrant an evaluation of the strategies and opportunities to increase equity in BP in the United States. Racial disparities in hypertension are largely driven by systemic inequities that limit access to quality education, economic opportunities, neighborhoods, and health care. To address these root causes, recent studies have evaluated evidence-based strategies, including community health workers, digital health interventions, team-based care, and mobile health care to enhance access to health education, screenings, and BP care in Black communities. In 2021, the American Heart Association made a $100 million pledge and 10 commitments to support health equity. This commitment included implementing multifaceted interventions with a focus on hypertension as a seminal risk factor contributing to disparities in cardiovascular disease mortality and morbidity. The American Heart Association is one organizational example of advocacy for equity in BP. Achieving equity nationwide will require sustained collaboration among individual stakeholders and public, private, and community organizations to address barriers across multiple socioecological levels.

Cancer Res. 2024 Sep 4;84(17):2761-2775. doi: 10.1158/0008-5472.CAN-23-2526.

Obesity induces temporally regulated alterations in the extracellular matrix that drive breast tumor invasion and metastasis

Sydney J Conner, Hannah B Borges, Justinne R Guarin, et al.

Obesity is associated with increased incidence and metastasis of triple-negative breast cancer, an aggressive breast cancer subtype. The extracellular matrix (ECM) is a major component of the tumor microenvironment that drives metastasis. To characterize the temporal effects of age and high-fat diet (HFD)-driven weight gain on the ECM, we injected allograft tumor cells at 4-week intervals into mammary fat pads of mice fed a control or HFD, assessing tumor growth and metastasis and evaluating the ECM composition of the mammary fat pads, lungs, and livers. Tumor growth was increased in obese mice after 12 weeks on HFD. Liver metastasis increased in obese mice only at 4 weeks, and elevated body weight correlated with increased metastasis to the lungs but not the liver. Whole decellularized ECM coupled with proteomics indicated that early stages of obesity were sufficient to induce changes in the ECM composition. Obesity led to an increased abundance of the proinvasive ECM proteins collagen IV and collagen VI in the mammary glands and enhanced the invasive capacity of cancer cells.

Cells of stromal vascular fraction and adipose stem and progenitor cells were primarily responsible for secreting collagen IV and collagen VI, not adipocytes. Longer exposure to HFD increased the invasive potential of ECM isolated from the lungs and liver, with significant changes in ECM composition found in the liver with short-term HFD exposure. Together, these data suggest that changes in the breast, lungs, and liver ECM underlie some of the effects of obesity on triple-negative breast cancer incidence and metastasis. Significance: Organ-specific extracellular matrix changes in the primary tumor and metastatic microenvironment are mechanisms by which obesity contributes to breast cancer progression.

Hypertension. 2024 Sep 4. doi: 10.1161/HYPERTENSIONAHA.124.22980. Online ahead of print.

Sex differences in hypertension and its management throughout life

Wan-Jin Yeo, Rahul Abraham, Aditya L Surapaneni, et al.

BACKGROUND: The prevalence of hypertension and uncontrolled hypertension may differ by age and sex.

METHODS: We included participants in the Atherosclerosis Risk in Communities study at seven study visits over 33 years (visit 1: 15 636 participants; mean age, 54 years; 55% women), estimating sex differences in prevalence of hypertension (systolic blood pressure ≥130 mm Hg; diastolic blood pressure ≥80 mm Hg; or self-reported antihypertension medication use) and uncontrolled hypertension (systolic blood pressure ≥140 mm Hg or diastolic blood pressure ≥90 mm Hg) using unadjusted and comorbidity-adjusted models.

RESULTS: The prevalence of hypertension increased from 40% (ages, 43-46 years) to 93% (ages, 91-94 years). Within hypertensive individuals, the prevalence of uncontrolled hypertension was higher in men (33%) than women (23%) at ages 43 to 46 years but became higher in women than men starting at ages 61 to 64, with 56% of women and 40% men having uncontrolled hypertension at ages 91 to 94. This sex difference was not explained by differences in coronary heart disease, diabetes, body mass index, estimated glomerular filtration rate, number of antihypertension medications, classes of medications, or adherence to medications. In both sexes, uncontrolled hypertension was associated with a higher risk for chronic kidney disease progression (hazard ratio, 1.5 [1.2-1.9]; P=4.5×10-4), heart failure (hazard ratio, 1.6 [1.4-2.0]; P=8.1×10-7), stroke (hazard ratio, 2.1 [1.6-2.8]; P=1.8×10-8), and mortality (hazard ratio, 1.5 [1.3-1.6]; P=6.2×10-19).

CONCLUSIONS: Sex differences in the prevalence of hypertension and uncontrolled hypertension vary by age, with the latter having implications for health throughout the life course.

Pediatr Nephrol. 2024 Sep 6. doi: 10.1007/s00467-024-06497-0. Online ahead of print.

Modification and scoring of a transition tool to understand transition readiness among pediatric kidney transplant recipients

Caitlin Peterson, Leandra Bitterfeld

BACKGROUND: A successful transition from pediatric to adult healthcare for adolescent and young adult kidney transplant recipients is essential for maintaining graft and overall health. Readiness for transition is multifactorial and can be challenging to assess. The purpose of this study is to describe the development of a scoring system for a transition readiness assessment for pediatric kidney transplant recipients and assess overall and domain-specific readiness for transition.

METHODS: This is an observational study of adolescent and young adult kidney transplant recipients over 5 years who were given either the modified Middle (MTRC-m) or modified Late Transition Readiness Checklist (LTRC-m) during post-transplant clinic visits. We developed a scoring system for both checklists and assessed their reliability.

RESULTS: The MTRC-m (38 items) demonstrated good reliability (Cronbach's α = 0.84). The LTRC-m (43 items) demonstrated excellent reliability (Cronbach's α = 0.90). On both the MTRC-m and LTRC-m, patients scored highest on adherence and risky behavior knowledge. Scores were lowest in the "Managing my healthcare needs (self-advocacy)" and "How I feel about myself" domains.

CONCLUSIONS: A scored transition assessment allows for rapid appraisal of transition readiness within a clinic Setting. We find that participants report high levels of knowledge regarding health-seeking behaviors and risky behaviors, endorse less readiness for managing their care independently, and express a moderate to high degree of worry about their future and their health. While transition programs have traditionally, and necessarily, focused on education, our Results demonstrate that programs should expand to also focus on behavior performance and emotional well-being.

Clin Transplant. 2024 Sep;38(9):e15456. doi: 10.1111/ctr.15456.

Risk and reward: nationwide analysis of cardiac transplant center variation in organ travel distance and the effects on outcomes

Benjamin D Seadler, Hamsitha Karra, James Zelten, et al.

BACKGROUND: The 2018 UNOS allocation policy change deprioritized geographic boundaries to organ distribution, and the effects of this change have been widespread. The aim of this investigation was to analyze changes in donor transplant center distance for organ travel and corresponding outcomes before and after the allocation policy change.

METHODS: The UNOS database was utilized to identify all adult patients waitlisted for heart transplants from 2016 to 2021. Transplant centers were grouped by average donor heart travel distance based on whether they received more or less than 50% of organs from >250 miles away. Descriptive statistics were provided for waitlisted and transplanted patients. Regression analyses modeled waitlist mortality, incidence of transplant, overall survival, and graft survival.

RESULTS: Centers with a longer average travel distance had a higher mean annual transplant volume with a reduction in total days on a waitlist (86.6 vs. 149.2 days), an increased cold ischemic time (3.6 vs. 3.2 h), with no significant difference in post-transplant overall survival or graft survival.

CONCLUSIONS: The benefits of reducing waitlist time while preserving post-transplant outcomes extend broadly. The trends observed in this investigation will be useful as we revise organ transplant policy in the era of new organ procurement and preservation techniques.

Am J Hematol. 2024 Sep 6. doi: 10.1002/ajh.27470. Online ahead of print.

Hodgkin lymphoma: 2025 update on diagnosis, risk-stratification, and management

Stephen M Ansell

DISEASE OVERVIEW: Hodgkin lymphoma (HL) is an uncommon B-cell lymphoid malignancy affecting 8570 new patients annually and representing ~10% of all lymphomas in the United States.

DIAGNOSIS: HL is composed of two distinct disease entities: classical HL and nodular lymphocyte predominant HL (also called nodular lymphocyte predominant B-cell lymphoma). Nodular sclerosis, mixed cellularity, lymphocyte depletion, and lymphocyte-rich HL are subgroups of classical HL.

RISK STRATIFICATION: An accurate assessment of the stage of disease in patients with HL is critical for the selection of the appropriate therapy. Prognostic models that identify patients at low or high risk for recurrence, as well as the response to therapy as determined by positron emission tomography (PET) scan, are used to optimize therapy.

RISK-ADAPTED THERAPY: Initial therapy for HL patients is based on the histology of the disease, the anatomical stage and the presence of poor prognostic features. Patients with early-stage disease are typically treated with combined modality strategies utilizing abbreviated courses of combination chemotherapy followed by involved-field radiation therapy, whereas those with advanced stage disease receive a longer course of chemotherapy often without radiation therapy. However, newer agents including brentuximab vedotin and anti-PD-1 antibodies are now standardly incorporated into frontline therapy.

MANAGEMENT OF RELAPSED/REFRACTORY DISEASE: High-dose chemotherapy (HDCT) followed by an autologous stem cell transplant (ASCT) is the standard of care for most patients who relapse following initial therapy. For patients who fail HDCT with ASCT, brentuximab vedotin, PD-1 blockade, non-myeloablative allogeneic transplant or participation in a clinical trial should be considered.

Diabetes Obes Metab. 2024 Sep 2. doi: 10.1111/dom.15900. Online ahead of print.

Patients with type 1 diabetes are at elevated risk of developing new hypertension, chronic kidney disease and diabetic ketoacidosis after COVID-19: up to 40 months' follow-up

Shiv Mehrotra-Varma, Justin Y Lu, Montek Singh Boparai, et al.

AIM: The aim was to investigate whether COVID-19 increases new incidence of hypertension (HTN), chronic kidney disease (CKD) and diabetic ketoacidosis (DKA) in patients with type 1 diabetes (T1D) up to 40 months post-infection.

MATERIALS AND METHODS: Three groups of patients from the Montefiore Health System in the Bronx (1 March 2020 to 1 July 2023) were studied: T1D patients hospitalized for COVID-19 (H-COVID-19, n = 511), T1D patients with COVID-19 but not hospitalized for COVID-19 (NH-COVID-19, n = 306) and T1D patients without a positive COVID-19 test on record (non-COVID-19, n = 1547). COVID-19 patients were those with a positive polymerase-chain-reaction test on record, and non-COVID-19 patients were either tested negative or not tested on record. Cumulative incidences and adjusted hazard ratios (aHR) with 95% confidence intervals (CI) were computed with adjustment for competing risks.

RESULTS: Compared to non-COVID-19 patients, both H-COVID-19 (unadjusted 19.72% vs. 3.14%, $p < 0.001$; aHR = 7.55 [3.33, 17.06], $p < 0.001$) and NH-COVID-19 (10.26% vs. 3.14%, $p = 0.004$; aHR = 5.08 [2.19, 11.78], $p < 0.001$) patients were more likely to develop new HTN. Compared to non-COVID-19 patients, both H-COVID-19 (11.41% vs. 1.14%, $p < 0.001$; aHR = 9.76 [4.248, 22.25], $p < 0.001$) and NH-COVID-19 (7.69% vs. 1.14%, $p < 0.001$; aHR = 6.54 [2.91, 14.67], $p < 0.001$) patients were more likely to develop new CKD. Compared to non-

COVID-19 patients, both H-COVID-19 (4.09% vs. 1.06%, $p < 0.001$; aHR = 12.24 [4.09, 36.59], $p < 0.001$) and NH-COVID-19 (3.06% vs. 1.06%, $p = 0.035$; aHR = 12.94 [4.09, 40.89], $p < 0.001$) patients were more likely to develop new DKA at follow-up.

CONCLUSION: T1D patients with COVID-19 are at higher risk of developing new HTN, CKD and DKA compared to T1D patients without COVID-19.

Am J Clin Oncol. 2024 Sep 6. doi: 10.1097/COC.0000000000001140. Online ahead of print.

Maintenance therapy in acute myeloid leukemia

Giorgi Sabakhtarishvili, Amir Ansari, Imad A Tabbara

Acute myeloid leukemia (AML) poses significant challenges due to its high relapse rates despite initial successful induction chemotherapy. Maintenance therapy aims to prevent disease recurrence, particularly in high-risk patients. This review explores current maintenance treatments, their impacts on patient outcomes, and ongoing studies shaping the treatment landscape for AML. Hypomethylating agents like azacitidine and decitabine have shown promise in improving relapse-free and overall survival, particularly in older patients with AML ineligible for transplantation. Combination regimens involving azacitidine and venetoclax have demonstrated encouraging outcomes post-hematopoietic stem cell transplantation. Targeted therapies, particularly FLT3 inhibitors like midostaurin and quizartinib, have shown significant benefits in improving survival outcomes, especially in FLT3-mutated AML cases. Gilteritinib and sorafenib also exhibit the potential to reduce relapse rates post-transplant. Isocitrate dehydrogenase inhibitors, including ivosidenib and enasidenib, present novel options for postchemotherapy and posttransplantation maintenance. Immunotherapies, such as Wilms tumor 1 peptide-based vaccines and checkpoint inhibitors, are being explored, although Results vary. Despite ongoing research, the role of maintenance chemotherapy remains uncertain, with inconsistent outcomes across trials. The approval of oral azacitidine represents a significant advancement, emphasizing the need for further investigation into personalized maintenance approaches. In conclusion, the evolving landscape of maintenance therapy and integrating targeted therapies in AML offers promising avenues for improving patient outcomes.

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18–65 years of age with an EDSS between 0 to 6.5 at screening. The demographics were similar and baseline characteristics were balanced across the two treatment groups. The mean age was 40 years in both groups. In the OCREVUS ZUNOVO group, 35% of patients were male and the mean/median duration since MS diagnosis was 5.7/3.1 years, compared to 41% male and 4.8/2.4 years in the ocrelizumab IV group.

HOW SUPPLIED/STORAGE AND HANDLING

OCREVUS ZUNOVO (ocrelizumab and hyaluronidase-ocsq) injection for subcutaneous use is a sterile, preservative-free, clear to slightly opalescent, and colorless to pale brown solution supplied as a carton containing one 920 mg and 23,000 units/23 mL (40 mg and 1,000 units/mL) single-dose vial (NDC 50242-554-01).

Store OCREVUS ZUNOVO vials refrigerated at 2°C to 8°C (36°F to 46°F) in the original carton to protect from light. Do not freeze or shake.

If necessary, OCREVUS ZUNOVO can be removed and placed back into the refrigerator. Unopened OCREVUS ZUNOVO vials may be stored in the original carton for a cumulative time of up to 12 hours without refrigeration at a temperature up to 25°C (77°F).

OCREVUS ZUNOVO is manufactured by Genentech, Inc., South San Francisco, CA.

CE2

Caring for Older Lesbian, Gay, Bisexual, and Transgender Adults: Implications for Case Managers

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From ICU to Case Management Operations: Passion for Meeting the Needs of People and Their Support Systems

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attending to the needs of the whole person and their support system.

My first case management position was with Optum/United Healthcare, my current employer, working as a telephonic case manager. Although the setting was far different than being on the floor in an ICU unit, my interactions with clients receiving case management services were much the same. I provided care coordination for those with complex needs, communicated in a way that promoted their understanding and helped close knowledge gaps for both the client and their support system.

Also at this time, I decided to return to school for a master's in business administration (MBA) with a focus on health care management. My goal was to develop business skills that would complement my clinical knowledge and experience. This led to my current position as a Manager for the Advisory Services team of Optum/UnitedHealth Care. In this consulting role in the provider space, I am currently working with a hospital system with three facilities to identify and implement improvements in their case management and utilization management functions.

As a lifelong learner, a trait I share with many CCMs, I am also pursuing a doctorate in health care administration. In addition, I have been proud to serve as a volunteer Commissioner of the CCMC and now as Chair-elect, to give back to the profession that represents a calling to serve others.

Looking back, I can see my passion for person-centered care and advocacy was seeded in nursing school and my first experiences in ICU. This is the common ground shared by all case managers, particularly those who are board certified, as articulated in the values of case management in the CCMC's Code of Professional Conduct for Case Managers.

Although we come from a variety of professional backgrounds with unique specializations, our focus is always on the individual and their support system—a holistic approach to health and well-being. CM

Legal Updates

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guardianship. Specifically, APS must consider guardianship only when there are not alternatives

- Requires responses within 24 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 2 ways, at least 1 of which must be online, to report maltreatment or self-neglect 24 hours per day, 7 days per week
- Requires robust conflict of interest policies to support ethical APS practice
- Establishes definitions for key APS terms to improve information sharing, data collection, and program standardization
- Promotes coordination and collaboration with state Medicaid agencies, long-term care ombudsmen, tribal APS, law enforcement, and other partners.

HHS points out that at least 1 in 10 older adults who live in communities experience some form of maltreatment each year.

All providers have been involved in situations in which APS are needed. Case managers and discharge planners in hospitals and long-term care facilities are especially likely to encounter and be expected to assist with situations involving 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 with regard to identifying situations in which APS is needed. At least anecdotally, however, providers have received very little assistance and support from APS in situations of abuse and neglect.

Hopefully, providers can look forward to greater assistance in view of enhanced funding and standards. CM

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Case Managers Are…

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Case managers are not built to carry all the weight of quality measures. It takes a team to move forward to a value-based world. Training each part of the team can immensely improve compliance and initiative from the health care team. Receptionists can be trained to identify if a patient has had a wellness visit. A medical assistant can follow up on the recommended screenings that were due during a previous wellness visit. A provider can provide education to patients on the importance of a wellness visit in hopes patients would comply and schedule the visit. All the while, case managers are managing the patient's care and ensuring coordination is completed.

In conclusion, a case manager is the coordinator of the patient's health. Interventions by case managers that come to mind that assist in improved health outcomes are helping an injured patient navigate through the rehab process or assisting with transportation to appointments. In addition, case managers can make sure a patient who has a fresh hip replacement receives a prescription for a blood thinner or help a homebound patient receive their medications through the mail instead of at the pharmacy. There is an array of things case managers assist with, but overall, they are the core reason a patient has high-quality health outcomes. There are opportunities for all health care providers to recognize and appreciate the value of case managers and their effects on their patients' lives through care coordination. CM

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Case Management Stress in an Already Stress-Filled World…How Are You Coping?

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on complex cases or those with ethical issues. This assistance can improve your skills, confidence, and performance and prevent the kind of isolation and detachment that can occur.

4. Practice continuous learning: case managers face constant challenges and changes in their role, which require them to adapt and learn new skills and knowledge. Coping with continuous learning can be stressful; however, increasingly, opportunities are available in traditional formats (workshops, conferences) as well as innovative formats (webinars, podcasts). Not only will this education increase your competence, but also it will raise your satisfaction.
5. Celebrate your achievements: we often focus more on the problems we encounter and the difficulties of our clients. This just elevates our frustration. It's important to celebrate our achievements and successes because they can serve as reminders of our purpose. Telling our story is not only essential but also an important tool to reinforce our contributions and success.

While the aforementioned steps to cope with the inherent stress in our roles as case managers are helpful, they are not absolute guarantors of success, but we can make a difference…one patient at a time!

We wish you continuing success as we celebrate you and case management. Thank you for what you do…every day!!

Warm regards,

Catherine M. Mullahy

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cmullahy@academyccm.org

Celebrating Case Managers

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process is now open. Fellow is a designation awarded by your peers based on your significant contributions to case management through leadership, practice, education, research, and/or community service. Becoming a Fellow gives you an opportunity to distinguish yourself by describing the impact you have made in case management. Since the 8 Founding Fellows were named, 20 distinguished case managers have been awarded the Fellow designation. Case managers who become Fellows use FCM after their name and professional designation. Look for that FCM! Perhaps you know a Fellow. In your career planning, you too might set your sights on becoming a Fellow. Being a Fellow is another way to celebrate case management. For more information and an application, please go to cmsa.org/about/fellow.

I salute all case managers, not just during National Case Management Week but every week of the year for the tremendous contributions you make in improving health care delivery and patient outcomes.

Gary S. Wolfe, RN, CCM, FCM,
Editor-in-Chief
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ACCM: Improving Case Management Practice through Education

Readers

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

Igniting the Power of Case Management: Celebrating Case Management Week 2024

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this session, led by Dr. Jin Yoon-Hudman, will highlight how combining physical and mental health services enhances patient outcomes—an area every case manager should feel empowered to champion.

Thursday, October 17, features a highly anticipated panel discussion on “AI & Ethics: Exploring Artificial Intelligence and Integrity in Case Management.” The rise of AI in health care is undeniable, and with it comes new ethical considerations. As case managers, our role as patient advocates makes it essential to understand and navigate these advancements while upholding integrity and human-centered care.

The week closes with a rejuvenating session on Friday, October 18, of a mini-webinar and chair yoga session, aptly titled “It’s Not About Touching Your Toes.” After a busy week of learning and networking, this 30-minute session, led by Sarah Stevenson, provides a much-needed break for busy case managers. Self-care is critical for maintaining our resilience, and this session reminds us to pause and invest in our well-being.

Finally, Saturday, October 19, brings the perfect conclusion to CM Week 2024 with a Case Manager Collaboration and Networking Session. Join Janet Coulter and other case management leaders at 12 pm ET for a live, interactive experience, where success stories and shared experiences will highlight the power of case management. This session not only allows us to reflect on our role in health care but also provides the inspiration to continue making a meaningful difference in the lives of patients.

And who says 1 week is enough to celebrate Case Management and Case Managers...as CMSA extends the celebration throughout the month of October!

On Wednesday, October 9, CMSA offers the “Making the Case: Strategies to Showcase Your Value” webinar, a valuable session for case managers looking to emphasize their impact in health care. This discussion provides tools to effectively communicate the value case managers bring to their organizations.

On Tuesday, October 22, the “Transforming Healthcare: The Legislative Impact on Patient Care” webinar takes center stage, delving into how changes in health care legislation are shaping patient care. This session, led by Matt Dennis, will provide key insights into policy changes and their practical impact on case managers and the patients they serve.

To round out the month, on Wednesday, October 30, a panel discussion titled “Navigating Patient Access to Care in Rural Communities” will focus on the unique challenges rural healthcare providers and case managers face. This session provides actionable strategies to improve patient access in underserved areas.

Empowering Our Future Together

The schedule for Case Management Week 2024 reflects our profession’s diverse challenges and triumphs. From DEIB and health equity to AI ethics and the integration of primary care with behavioral health, these sessions represent the cutting edge of healthcare. As case managers, we are at the forefront of these trends, ensuring that care coordination, advocacy, and patient-centric strategies are carried out every day.

But Case Management Week isn’t only about professional growth—it’s about taking pride in the work we do. It’s an opportunity to remind ourselves and others of the incredible impact we have on the healthcare system. Our role extends beyond merely coordinating care; we are the vital link between patients and the resources they need to navigate the complexities of healthcare systems.

Join Us for Case Management Week 2024!

With virtual events and webinars accessible to all—whether you’re a CMSA member or not—there’s no reason to miss out on CM Week 2024. Every session is designed to equip you with valuable knowledge, new perspectives, and connections that will fuel your passion for the work we do. Plus, with prizes being awarded at each event, there’s even more incentive to participate fully throughout the week.

As we move forward into a future where healthcare is more complex yet more interconnected than ever, Case Management Week 2024 stands as a reminder of the crucial role we play. We are not just managing cases; we are transforming lives, one patient at a time.

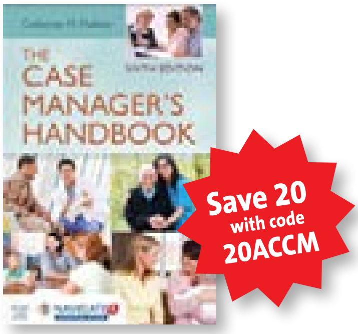
Mark your calendars for October 13–19, 2024, and get ready to celebrate Case Management Week! Let’s come together to learn, grow, and power the future of healthcare.

For more details on the schedule and how to participate, visit the CMSA CM Week Page at cmsa.org/about/national-cm-week/. See you there! CM

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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Q: How long does it take to process CE exams?
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application on next page

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