CareManagement

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

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Gary S. Wolfe

Case Management Fellows

By Gary S. Wolfe, RN, CCM, FCM, Editor-in-Chief

The Case Management Fellows Class of 2025 was recently announced at the Annual CMSA Conference, and I am pleased to salute, recognize, and honor these distinguished individuals.

Class of 2025

- Dr. Raine Arndt-Couch, DSW, JD, LCSW, CCM, FCM, Yorba Linda, CA
- Elaine Bruner, MSN, RN, CMGT-BC, FCM, Chesapeake, VA
- Dr. Vivian Greenway, PhD, MSA, BSN, RN, CCM, PAHM, FCM, Southfield, MI
- Kathy Parry, BSN, RN, CCM, FCM, Sammamish, WA
- Susan Plough, MSN, RN, PHCSN-BS, CCM, FCM, Kokomo, IN

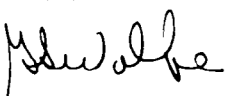
Each of these individuals has had a profound impact on the professional practice of case management in various ways. They have distinguished themselves through leadership, innovation, practice, and scholarship. Case Management Fellows (FCM) represent a diverse community of accomplished thought leaders who take an active role in identifying future trends and issues affecting case management. They serve the public and the professional practice of case management by advancing the standards of practice through excellence.

The CMSA Case Management Fellows Program was launched in 2021 to recognize those individuals who have made a significant contribution to and have had a lasting impact on case management. Contributions can be made through leadership, practice, research, and education. Fellows have published their stories and shared them with the world. Case management now has 28 Fellows, including 8 Founding Fellows.

The criteria to become a Fellow are rigorous. The application process captures information about the applicant and their contributions, with supporting documentation. Applications for the Class of 2026 will open this October during National Case Management Week. Perhaps you have made a significant contribution to case management. Think about it, review the criteria, and apply.

The bar is high for becoming a Fellow. I salute and honor the above individuals, for they have met the bar. As Fellows, they will continue to lead the professional practice of case management.

Congratulations to the FCM Class of 2025!



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ACCM: Improving Case Management Practice through Education

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Catherine M. Mullahy

Innovation: Can Each Case Manager Become an Innovative Leader?

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

Innovation has become the latest buzzword in health care, including case management. What does it really mean? Innovation in case management refers to the introduction of new approaches, technologies, or practices that enhance the effectiveness and efficiency of managing client cases. These innovations can include leveraging technology for better communication and data collection, adopting evidence-based practices, or developing new models and tools for streamlining processes.

If you've been paying attention, conferences, seminars, journals, newsletters, and blogs are discussing the importance of embracing innovative, strategic solutions to the complex problems our patients are facing. As you become increasingly aware of the need for innovation, do you think that need refers to each case manager, or is innovation just for those in leadership positions? For those of you who are new to case management, did you know that each case management professional is, in fact, a leader? Take a closer look at our Standards of Practice (CMSA Standards of Case Management Practice | CMSA), and you will see the responsibilities that we have. Surely, each case manager assumes a leadership role in the many practice settings where we are located, either as an employee or as an independent practitioner. Those case managers who are more experienced are called on to mentor the next generation of practitioners.

For those of you who are new to case management, did you know that each case management professional is, in fact, a leader?

Fortunately, there are strategic and readily available solutions that we can use to become innovative case managers. Hopefully, the following will provide you with some "food for thought":

- **Engage Online**: Numerous online platforms can keep you apace with industry changes. Joining professional networks and forums dedicated to case management can offer insights and emerging trends and shared challenges. Most of these provide opportunities to engage in discussions with thought leaders about how to implement new strategies in your practice.
- **Attend Events:** Workshops, seminars, and conferences are excellent opportunities to learn about the latest innovations in case management. These events not only provide in-depth knowledge on specific topics but also allow you to network with other professionals. Some of the sessions offer opportunities to explore how pilot projects in other organizations are improving patient outcomes and serving as virtual "footprints" that might be applicable in your practice setting. Would a program that you and your colleagues created be eligible for a presentation at a future conference?
- **Utilize Tools:** Embracing new technologies and software can significantly enhance your case management processes. Consider joining a team in your organization that evaluates new systems; you can be an active representative for your case management team to ensure that new technologies meet case management needs.
- **Professional Growth:** Continuous professional development is essential to staying abreast of innovations in case management. Pursuing certification or advanced degrees can deepen your understanding of the field and expose you to "best-in-class" evidenced-based practice. Knowledge is power, and one of the easiest ways to obtain it is through reading. Continuous learning is a hallmark of a professional!
- **Reflect Regularly:** Self-reflection is a powerful tool for personal and professional growth. It's always helpful to assess the effectiveness of your case management intervention, the feedback that your clients

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New Exam Blueprint for the Certified Case Manager (CCM) Credential

By MaryBeth Kurland, MPA, CAE, ICE-CCP

For three decades, the Commission for Case Manager Certification has conducted field surveys of professional case managers, particularly those who are board-certified. These surveys (known as role and function studies or job task analyses) capture the knowledge and areas of expertise required for competent practice in case management.

From one survey to the next, conducted every 5 years starting in 1994, the Commission has amassed a robust body of research that ensures the relevance of the Certified Case Manager (CCM) certification and examination content. This legacy continued with the completion of the 2024 job task analysis, results of which were recently published in Professional Case Management. Based on the latest findings, the CCM certification examination blueprint has been updated, starting with the exam administered in August 2025.

The case management workforce has become increasingly professionalized, with 85% of respondents holding a minimum of a bachelor's degree (an increase from 81% in 2019); 36% possessing a master's degree (32% in 2019), and nearly 3% with a doctoral degree (2% in 2019).

The most significant change is that the certification exam now covers six knowledge domains with specific weightings (i.e., the number of questions asked) assigned to each: Care Management (30%), Reimbursement Methods (12%), Psychosocial Concepts and Support Systems (20%), Quality and Outcomes Evaluation and Measurements (10%), Rehabilitation Concepts and Strategies (10%), and Ethical, Legal, and Practice Standards (18%).

Previously, the CCM examination blueprint (based on the 2019 job task analysis) had five domains, the first of which was Care Delivery and Reimbursement Methods. Based on findings from the 2024 survey, this domain was split to create two separate areas, as noted above. The creation of a separate Care Management Domain, as the first and largest of the domains, emphasizes the importance of care management across all care settings and specializations.

Changes in Job Titles

The 2024 job task analysis also revealed several informative trends in case management. Among them is the evolution of job titles. In the 2024 survey, the most common titles were nurse case manager (19% of respondents) and case manager (17%), along with care manager (10%) and care coordinator (4.6%). In total, these titles account for nearly 55% of survey participants. This represents lesser prevalence of the care/case manager title, declining from 82% in 2004 to 65.6% in 2009, 59.5% in 2014, and 52.7% in 2019. Importantly, the decrease in the care/case manager title should not be interpreted as any diminishment in the importance of case management or care management practices. Rather, it reflects the fact that case managers are known by various titles, depending on their practice setting.

Other trends revealed in the 2024 survey include:

- The case management workforce has become increasingly professionalized, with 85% of respondents holding a minimum of a bachelor's degree (an increase from 81% in 2019); 36% possessing a master's degree (32% in 2019), and nearly 3% with a doctoral degree (2% in 2019).
- Based on survey responses, 41% of employers continue to require certification in case management,

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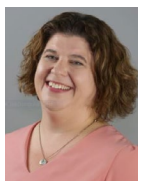

MaryBeth Kurland, MPA, CAE, ICE-CCP, *is the Chief Executive Officer of the Commission for Case Manager Certification. The Commission is the first and largest nationally accredited organization that certifies more than 50,000 professional case managers and disability management specialists. With more than 25 years of experience in the nonprofit sector, she is also a credentialing segment leader at an association management company where she oversees the strategic direction and operational excellence of credentialing programs for several associations and organizations, including CCMC.*

Celebrating Case Managers at CMSA

By Janet Coulter, MSN, MS, RN, CCM, FCM

Whether you are logging on from your office or joining us in person, this fall is packed with opportunities to connect, learn, and lead like never before.

There is always something energizing about fall! The leaves begin to change, the air turns crisp, days seem to be shorter, and students return to school. It's time for football, bonfires, and sweaters! It's a season that invites both reflection and renewal. At CMSA, we believe fall is the perfect time to celebrate the incredible work case managers do. To celebrate, we are investing in your personal and professional growth. Whether you are logging on from your office or joining us in person, this fall is packed with opportunities to connect, learn, and lead like never before.

It all begins in September. Join us in Nashville, September 24–26 for CMSA Case Management Boot Camp. This interactive course is designed for case managers with 5 years' or less experience or those transitioning into a new area of practice. It is an immersive, three-part, in-person training event that delivers foundational tools, strategic insights, and practical knowledge. Often, case managers "learn on the job" and are not exposed to knowledge and skills that advance the practice of case management. Boot Camp is designed to give case managers an opportunity to lay a solid foundation and build the skills needed to practice evidence-based case management. Whether you are new to case management or looking to sharpen your skills, CMSA's Boot Camp will help you grow, connect, and succeed.

New this year is the CMSA's Virtual Leadership Conference on October 11. This conference is tailored for mid- to senior-level managers and executives who work with case managers. This innovative conference will highlight case management as an evolving health care industry and provide the needed tools to advance our profession. Included will be sessions on financial management strategies, culture, and how to influence the C-Suite. Additionally, there will be opportunities to network with peers and industry leaders. This virtual gathering is your opportunity to elevate your leadership skills and build new momentum for your team and organization.

The celebration continues with National Case Management Week, October 12-18! National Case Management Week recognizes the vital impact case managers make daily in the lives of the people we serve. CMSA's inspiring theme this year is "Innovate. Advocate. Celebrate Case Management!" CMSA will be celebrating the entire month of October with bonus education in honor of the heart and soul of health care: case managers! CMSA will offer continuing education credits (including RN, SW, CCM, CCM Ethics, CDMS, CDMS Ethics, CMC, and CNLCP), networking opportunities, prizes, and plenty of FUN! Go to cmsa.org/about/national-cm-week to grab your Case Management Week gear, download celebration resources, find tips and tools for Case Management Week celebrations, and download logos and Zoom backgrounds.

Don't forget to share how you are celebrating National Case Management Week on social media using #CMWeek2025. Whether it's a team luncheon, a creative display, or a favorite moment from a webinar, we want to see how you are honoring the profession. Tag CMSA for a chance to be featured and inspire others!

Rounding out Case Management celebrations is Virtual MVD Day (Military, Veterans, Department of Defense, and Defense Health Agency) on November 1. This outstanding one-day educational event was rescheduled from an in-person event to a virtual event to better meet the needs of our MVD case managers. Virtual MVD Day is tailored for case managers working in military services and focuses on key topics to enhance their case management skills. MVD Day will include topics such as interpersonal violence, coordinating and advocating for innovative solutions, and strategies to support military and veteran

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Janet Coulter, MSN, MS, RN, CCM, FCM, *is the President of CMSA and a Fellow of Case Management. For the past 3 years, she has been providing case management services for solid organ and bone and marrow transplant patients.*

Legal Updates

By Elizabeth E. Hogue, Esq.

"Her Toes Fell Off In My Hand"

We sometimes lose sight of the traumatic experiences that many practitioners have in every practice setting. Such experiences can lead to emotional numbing that may interfere with the ability of staff to provide empathy and quality care for patients. The inability to do so may increase the risks of legal liability.

Here are many horrifying, devastating examples, some of which appeared on AOL on June 18, 2025:

- "Carrying a stillborn infant to the morgue in my arms so that her mother did not have to see her on the cold morgue cart. This was against policy. It was night shift, and I didn't care. The look on her face and the pain in her voice asking me to carry her will stay with me forever."
- A home care nurse fell through the floor of a patient's home and was severely injured.
- "Sitting with a 5 yo who was there for a suicide attempt and his mom just dropped him off and gave his info and left. He then ran out of the ER into oncoming traffic and when I caught him, he grabbed onto me and said, "'I just want my mommy to love me.'"
- "Sane (sexual assault) exam on a 8-month-old baby…I never went home and cried so much. I held my daughter when I got home."
- "Praying with an older couple before surgery to go well; she didn't make it. Watching him leave alone with his cane and hat in hand."
- "Holding a patient by his gait belt with another nurse so he could dance with his wife one last time. He passed that night. Her cries haunt me."
- Finding a home health patient with her skin adhered to her mattress.
- "Doing compressions on a man still in his wedding tuxedo while his brand-new wife stood outside the room still in her dress. They were t-boned leaving their wedding. He didn't make it."
- "During an honor walk hearing the scream of a mother and watching her fall to her knees as her teenage son was being wheeled down to the OT to be an organ donor."
- "When an old lady was sick, and I hugged her, and she started crying and said all she wants is her mommy."
- "Being a nurse in ICU. Caring for a 25 yo woman who got H1N1 and was on life support for over a month. Pressors, vent, the whole 9. Family was never there but wouldn't take her off life support. I took her sock off and her toes fell off into my hand. She was rotting. Had to call ethics committee."
- "Losing my 8-week-old daughter and my boss calling me the next day asking when I'd be returning to work, on the pediatric floor."
- "Seeing a man in his 80s being dropped off (old folks' home) and his daughter saying she'd pick him up later for his grandbaby's soccer game. He sat by a window waiting everyday. They never even came to get his belongings when he passed."
- "My favorite patient; I work in memory care, and she knew EVERYTHING about me. I laid in bed with her during her final days. She told me she'll always be rooting and watching over me. She told me to stay on earth for as long as I can."

Staff members need and deserve our compassion and care so that they can care for patients.

"Painting Pictures" of Patients

As the fight against "fraud, abuse, and waste" continues, responding to audits has become an ongoing burden for many providers. Providers have repeatedly been urged to "paint a picture" of patients in clinical documentation to help achieve positive results. "Painting a picture" of the patient, however, may have become more difficult as the use of electronic health records (EHRs) has increased. That is, it's difficult to adequately describe patients' conditions when there are so many boxes to check and blanks to fill in.

In addition, when it comes to narrative descriptions of patients' conditions, it is extremely tempting to "copy and paste," "cut and paste," and/or "copy forward" previous documentation in the EHR. The copy and paste feature allows users to use the content of another entry and to select information from an original or previous source to reproduce in another location. The copy forward capability replicates all or some information from a previous note to a current note, while the cut and paste feature removes documentation from the original location and places it in another location. In

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

CE1 Approved for 1 hour of CCM, CDMS, and nursing education credit
Exam expires on February 17, 2026

Aging with HIV: Updates and Implications for Case Managers

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

The Centers for Disease Control and Prevention (CDC) (2025) estimates that nearly half of all persons in the United States living with HIV are 55 years of age or older; that percentage is expected to increase over the next decade. This is a shift from the mid-1980s when the average life expectancy following an AIDS diagnosis was approximately 3 years (NIH, n.d.). With advances in HIV antiretroviral therapy (ART), along with expanded screening and early detection, mortality from HIV has declined. A recent analysis found that a person diagnosed with HIV today and started on ART can have a life expectancy that approximates that of a person without HIV (Trickey et al., 2023).

With this shifting paradigm from a fatal illness to a chronic disease, clinicians and health systems must adapt to meet the unique aspects of aging with HIV. For case management professionals, awareness of the issues facing people aging with HIV is critical to the provision of patient-centered, chronic disease management. Older people with HIV (PWH) are not only susceptible to the effects of long-term HIV ART but are at risk for developing other chronic conditions such as cardiovascular, metabolic, renal, and neurocognitive issues. Many PWH require the skills and knowledge of case managers who are familiar with navigating the complexities of the health care system and ensuring that all chronic conditions are managed appropriately, and lapses in care are minimized. This article reviews key aspects of HIV, summarizes a few of the differences in caring for older PWH, and discusses implications for case management professionals.

Epidemiology

Approximately 1.2 million individuals are living with HIV in the United States with the largest percentage of cases occurring in males (77%) compared to females (23%) (CDC, 2025). In terms of HIV incidence, there were 39,201 new diagnoses reported in 2023 (CDC, 2025). Although most cases occurred in younger individuals, there were nearly 4,000 new cases identified in persons over age 55. Among this group, male-to-male sexual transmission was the most common route of HIV acquisition (47%). Forty-one percent of new cases were reported to be through heterosexual transmission, and approximately 9% through injection drug use (CDC, 2025). Racial and ethnic disparities among newly diagnosed PWH over 55 were similar to the demographic trends among younger individuals. There were racial and ethnic disparities among those who were newly diagnosed with HIV: 38% were Black/African American and 23% were Hispanic/Latino (CDC, 2025). Unlike younger individuals, more than 30% of those diagnosed over age 55 tended to be at a more advanced stage of HIV infection (CDC, 2025). This may be reflective of several important issues, including the potential that routine HIV screening and testing, as well as access to HIV prevention interventions, such as HIV pre-exposure prophylaxis (PrEP), are not being offered to older persons.

HIV Transmission, Pathogenesis, and Natural History

HIV is transmitted from person-to-person through certain bodily fluids, primarily blood, semen, vaginal secretions, and breast milk (CDC, 2024). Following infection with HIV, the virus targets the CD4+ lymphocyte (or T4+) cell, a key component of the immune system. Once attached to the CD4+ cell, HIV integrates its genetic material into the CD4+ cell's nucleus where it goes through a process of reverse transcription to make additional viral strands (Swinkels et al., 2024). In essence, HIV uses the CD4+ cell as a factory to replicate and produce more virus. Once additional HIV virions are created, the CD4+ cell is destroyed, and newly created HIV

Jeffrey Kwong, DNP, MPH, AGPCNP-BC, FAANP, FAAN, *is an HIV specialist and nurse practitioner at NYU Langone Health in New York City. He is the Co-Medical Director for the American Academy of HIV Medicine's HIV and Aging Program, has served on the Association of Nurses in AIDS Care's HIV and Aging Expert Panel, and was previously a Clinical Ambassador for the Centers for Disease Control and Prevention's "Let's Stop HIV Together" program.*

The number of persons with HIV over the age of 55 is expected to increase significantly over the next 10 years.

is released into the bloodstream. Over time, without any ART, the amount of HIV increases and the CD4+ cell count declines, making individuals less able to mount an immune response. Once the CD4+ cell count drops below a certain threshold (typically < 200 cells/μl), a person becomes susceptible to opportunistic infections and diseases that would normally be controlled in those with an intact immune system. Infection with these opportunistic pathogens ultimately leads to mortality.

HIV Treatment

Combination Therapy. Current HIV ART regimens use a combination of drugs from different classes that inhibit or prevent HIV replication. By suppressing viral replication, a person's immune function is preserved and the risk of transmission of HIV is reduced. The primary classes of drugs used in contemporary HIV treatment regimens include nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs) paired with either an integrase strand transfer inhibitor (INSTI), a non-nucleoside reverse transcriptase inhibitor (NNRTIs), or a protease inhibitor (PI) (Table 1). Unlike earlier forms of ART that required multiple pills to be taken several times a day, once-daily, single-tablet regimens (STR) that combine multiple classes of drugs into one pill have proliferated (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2024). Additionally, the side effects of most first-line ART options are usually well tolerated.

Long-Acting Treatment. One of the more exciting developments in HIV therapy is the introduction of long-acting treatment. Currently, long-acting treatment consists of long-acting injectable (LAI) regimens. However, clinical trials are investigating options for long-acting oral ART, but none has yet been approved by the Food and Drug Administration (FDA). Not all PWH can take or use the current FDA-approved LAIs due to issues including previous drug resistance, side effects, insurance coverage, or logistical problems (the injectables need to be administered by a medical provider, and some people may be challenged with coming to a clinic or office on a frequent basis). One of the advantages of long-acting treatment is decreased pill burden. This may help improve

TABLE 1 EXAMPLES OF HIV ANTIRETROVIRALS

Drug Class	Generic Name (Abbreviation)	Examples/ Brand Name (Combination Drug)
Nucleoside/Nucleotide Reverse Transcriptase Inhibitor (***NRTI***)	• Emtricitabine (FTC) • Lamivudine (3TC) • Tenofovir Alafenamide (TAF) • Tenofovir Disoproxil Fumarate (TDF)	Descovy® (TAF + FTC) = NRTI only* Truvada® (TDF + FTC) = NRTI only*
Integrase Strand Transfer Inhibitor (***INSTI***)	• Bictegravir (BIC) • Cabotegravir (CAB) • Dolutegravir (DTG)	Biktarvy® (BIC + TAF+ FTC) = INSTI+NRTI Cabenuva® (CAB + RPV) = INSTI+ NNRTI Tivicay® (DTG) = INSTI only Dovato® (DTG + 3TC) = INSTI + NRTI
Non-Nucleoside Reverse Transcriptase Inhibitor (***NNRTI***)	• Doravirine (DOR) • Rilpivirine (RPV)	Pifeltro® (DOR)* = NNRTI only Delstrigo® (DOR+TDF+3TC) = NNRTI + NRTI Cabenuva® (CAB+ RPV) = INSTI+ NNRTI Juluca® (DTG+RPV) = INSTI+NNRTI
Protease Inhibitor (***PI***)	• Darunavir (DRV)	Symtuza® (DRV+COBI+TAF+FTC) = PI+NRTI **

**Single class combination tablets. For HIV treatment, medication must be combined with at least one other class of drugs to form a complete HIV treatment combination.*

***Cobicistat (COBI) is a pharmacokinetic enhancer that boosts levels of darunavir. It has no activity against HIV.*

Persons with HIV are more likely to develop other chronic conditions at earlier ages compared to the general population.

adherence to treatment, especially in older individuals who may take multiple medications for other chronic conditions.

Treatment Initiation. The recommendation of when to initiate HIV ART is the same for all individuals, regardless of age (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2024). Current recommendations are to start ART as soon as possible after diagnosis, regardless of CD4+ count, viral load, or availability of HIV drug-resistance assay results. This is a shift from earlier recommendations when treatment was postponed until HIV drug resistance testing results were available, or until the CD4+ count reached a certain threshold. These previous recommendations were more relevant when there were limited treatment options and the side effects from treatment were significant. Data have shown the benefit of early treatment, including faster time to viral suppression, preserved immune function, and decreased risk of transmission to others (Lundgren et al., 2023). Of note, data suggest that although older PWH may be able to achieve viral suppression at the same rate as younger individuals, the level of CD4+ cell recovery may be attenuated (Li et al., 2024). This supports the importance of early diagnosis and prompt treatment to preserve immune function.

Drug Resistance and Heavily Treatment-Experienced Individuals. Another aspect of caring for older PWH is the greater possibility of HIV ART drug resistance. Individuals who were diagnosed in the late 1980s through the early 2000s may have been on earlier generation treatments or were treated in the era before the use of combination therapy. As a result, some individuals may have virus that is resistant to multiple classes of HIV ART. Referred to as heavily treatment-experienced (HTE) individuals, this group may require more complicated treatment regimens, are more likely to have other medical complications, and are at higher risk of mortality (Priest et al., 2021).

HIV, Inflammation, Aging, and Co-Morbidities

Although HIV ART works by suppressing viral replication, evidence suggests that even in persons who have well-controlled HIV, there may be ongoing cellular inflammation (Chauvin & Sauce, 2022). This ongoing state of chronic cellular inflammation is thought to be one of the primary drivers of other co-morbidities in PWH. Data from various studies indicate that PWH experience earlier occurrence and greater frequency of common co-morbidities than persons without HIV (Collins et al., 2023). The range of chronic co-morbidities that occur in older PWH are similar to those without HIV, and include atherosclerotic cardiovascular disease, metabolic conditions (such as diabetes, steatoic liver disease, and osteoporosis), renal disease, neurocognitive disorders, and malignancies. It is beyond the scope of this article to highlight all the conditions that may affect older PWH. However, we will highlight some of the recent research findings in several key domains.

Cardiovascular Disease. Research has shown that the rate of atherosclerotic cardiovascular disease is nearly twice as prevalent in PWH than in persons without HIV (Zhu et al., 2024). This suggests a combination of factors, including HIV infection itself, side effects of ART, as well as other modifiable risk factors, such as tobacco use. One of the challenges of managing and preventing cardiovascular disease is that traditional risk prediction tools (such as the American College of Cardiology/American Heart Association's Atherosclerotic Cardiovascular Disease [ASCVD] Risk Calculator or the Framingham Risk Calculator) do not account for effects of HIV and have been shown to underpredict cardiovascular risk in PWH (Grinspoon et al., 2024). However, in 2024, results from a large, multinational trial conducted exclusively in PWH, called the Reprieve Trial, found that early intervention with pitavastatin in persons who were traditionally considered "low risk" for a cardiovascular event, resulted in a 35% reduction in time to first major cardiovascular event (Grinspoon et al., 2023). This finding led to an update in clinical guidelines. Use of statin therapy is now recommended for nearly all PWH ages 40 to 75 (Table 2) (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2024).

Neurocognitive Disorders. HIV-Associated Neurocognitive Disorder (or HAND) refers to a constellation of neurocognitive changes that may be seen in PWH. HAND is divided into asymptomatic neurocognitive impairment (ANI), mild neurocognitive disorder (MND), or HIV-associated dementia (HAD) (Elendu et al., 2023). Each category of HAND is based on performance on standardized neuropsychological testing. Laboratory and clinical assessment are also used to help in the diagnosis and classification of disease. A person is given a diagnosis of HAND once other causes of cognitive change, such as opportunistic infection, malignancy, stroke, substance use, withdrawal, or other acute encephalopathy, are excluded. Risk factors that have been associated with development of

TABLE 2 RECOMMENDATIONS FOR STATIN USE IN PERSONS WITH HIV AGE 40–75 YEARS

Initiate a moderate intensity statin when 10-year Atherosclerotic Cardiovascular Disease Risk (ASCVD) risk estimates are 5% to <20%. • Recommended options: – Pitavastatin 4mg or – Atorvastatin 20mg or – Rosuvastatin 10mg When 10-year ASCVD risk is <5%, moderate-intensity statin is also recommended although absolute benefit is modest and decision to initiate should take into consideration presence or absence of HIV-factors that can increase ASCVD risk.
For persons with 10-year ASCVD risk >20%, initiate a high-intensity statin.
For persons 40-75 years with HIV and diabetes, initiate a moderate-intensity statin. Assess for other risk factors to determine need for high-intensity statin.

Source: *Panel on Antiretroviral Guidelines for Adults and Adolescents. (2024). Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services.*

HAND include advanced HIV disease, longer duration of HIV infection, poor adherence to ART treatment, aging, substance use, and other chronic conditions like hypertension and cardiovascular disease (Elendu et al., 2023). Unfortunately, limited treatment options for HAND exist. If a person is not currently on ART, then ART should be initiated. Lifestyle modification, including tobacco cessation, aerobic exercise, and control of other co-morbid conditions is also beneficial (Nweke et al., 2022).

Malignancy. PWH are at greater risk for developing certain malignancies compared to persons without HIV (NCI, n.d.). For example, rates of anal cancer are estimated to be 20 times higher; Burkitt's lymphoma, 15 times higher; cervical cancer, 3 to 4 times higher; liver cancer, 2 times higher; and lung cancer 1.6 times higher in PWH versus persons without HIV (NCI, n.d.). The elevated risk for malignancy is thought to be multifactorial and related to immune suppression, co-infection with other viruses that are associated with cancer (such as human papilloma virus and chronic viral hepatitis), tobacco use, and persistent cellular inflammation (Omar et al., 2024).

As with all cancers, prevention and early detection are important aspects of long-term survival and outcomes. A few important differences exist for cancer screening in PWH compared to the general population. For cervical cancer, screening for PWH should be continued for a person's lifetime, compared to discontinuing at age 65 in the general population (Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV, 2024).

Given the significantly higher risk of anal cancer, guidelines exist for anal cancer in PWH (Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV, 2024). Anal cancer screening involves at a minimum a digital anal rectal exam. Additional screening for cellular abnormalities with anal cytology (similar to a cervical pap smear) can detect cellular dysplasia in the anal canal. Persons with abnormal anal cytology are then referred for further evaluation with high-resolution anoscopy (HRA), which is analogous to cervical colposcopy. During HRA, biopsy of abnormal tissue is usually sent for pathology to confirm a diagnosis. One of challenges of anal cancer screening is the lack of trained providers skilled in HRA. If HRA services are not available, the guidelines recommend an annual digital rectal exam and assessment of any symptoms (such as anal pain or bleeding). It is important to note that anal cancer screening is different than colon cancer screening. Anal cancer is typically localized to the lower part of the rectal canal. Colon cancer involves other parts of the colon and large intestines. Screening for anal cancer should begin at age 35 for men who have sex with men and transgender women, and age 45 for all others (Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV, 2024).

Screening recommendations for lung, breast, prostate, and colon cancer are the same for PWH as the general population. Unfortunately, an analysis of PWH who received appropriate age-based screenings found disparities in care, with lower preventive cancer screening rates in PWH compared to persons without HIV (McGee-Avila et al., 2024).

Models of Care and the Role of Case Management

A recent scoping review by Kokorelias, et al. (2023) examined models of care for older PWH. Although various models exist, there were three key characteristics among successful models of care: 1) collaboration and integration of care; 2) organization of geriatric care; and 3) support for holistic care. As with all care for older adults with multiple chronic conditions, collaboration and integration of care is critical. Often management of persons with multiple chronic conditions involves numerous specialists and sub-specialists. Care models that facilitate communication and provide integrated care often are the most successful in terms of quality, patient safety, and patient satisfaction. Case management professionals can serve a vital role in these instances to ensure that continuity of care and communication among all members of the health care team remain open and consistent across specialists and settings. In one analysis by Zhang et al. (2022), only one-third of nursing home residents with HIV were on appropriate HIV ART. They found that older persons, those with multiple co-morbidities, and those in nursing homes with limited HIV expertise were factors associated with not being on HIV ART.

Prevention and early screening of other co-morbidities can help reduce complications and morbidity for persons aging with HIV.

Instances like this highlight how case managers could play a critical role in providing continuity of care across health care settings and serving as educators and advocates for older PWH who may not be able to advocate for themselves.

In terms of access to geriatric specialists, a model of care that has been used is to have a geriatric consultant integrated within a dedicated HIV clinic or health center. Other systems have patients go outside of their regular health setting to see an off-site geriatric specialist. Having a system and referral network that includes interprofessional team members who are knowledgeable about HIV and aging is important. Team members include not only medical specialists but other service providers such as rehabilitation specialists (physical therapy, occupational therapy), home care providers, mental health professionals, nutritionists, and oral health professionals. Case managers can also play a vital role here in making sure the referral systems and the providers within external referrals are welcoming and up to date on HIV management. Regardless of how the care and team structures are developed, it is important that health systems offer support and care that recognizes the unique challenges and experience of persons aging with HIV (Brown & Adeagbo, 2021).

HIV Stigma and Retention in Care

Stigma related to HIV is a concern for all PWH, regardless of age. However, among older PWH, stigma and discrimination may be amplified and layered on top of other intersecting issues, such as ageism, homophobia, transphobia, racism, substance use, ableism, and poverty, to name just a few (Johnson Shen et al., 2019). It is important for care providers and health systems to acknowledge and be mindful of the impact of stigma. HIV stigma and fear of discrimination have been associated with higher rates of depression and mental health conditions, decreased adherence to treatment, and loss to follow-up. Fostering trusting relationships with patients and taking measures to provide care that is unconditional and free from judgment and stereotyping provides a foundation for success.

The HIV Care Continuum

The HIV care continuum is a public health framework that measures the percentage of individuals during critical points in care delivery, from diagnosis to achieving viral suppression. Metrics used as part of the HIV care continuum include the percentage of individuals living with HIV who are aware of their HIV status, the percentage who are linked to HIV care, those who receive HIV medical care, those who are retained in care, and those who achieve viral suppression. Although the ideal goal would be to have 100% in all metrics, recent data indicate that approximately 83% of PWH were linked to care within the first month of diagnosis; 76% of all PWH received some form of medical care; and 67% achieved viral suppression (CDC, 2025).

Retention in care and achievement of viral suppression are paramount to ensuring that PWH achieve optimal health outcomes, but they are also critical for ending the HIV epidemic both domestically within the United States as well as globally. It is important to recognize that every provider plays a role in this health initiative. Case managers are one of those vital links in helping achieve this global health initiative.

Conclusion

Advances in HIV treatment along with novel HIV prevention interventions have helped transform the understanding of HIV over the past four decades. Now considered a chronic condition, health systems must prepare to care for a population of adults living with HIV who are now aging into older adulthood. Case managers are ideally positioned to help optimize care for this population by engaging clients in care, helping them stay in care, advocating for preventive services, and working to reduce stigma within the health system. By working together with patients, the community, health systems, advocates, and policy makers we can transform the idea of ending the HIV pandemic from a goal to a reality. CE1

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The Unraveling of Health Equity: Case Management's Ethical Dilemma

By Tiffany Ferguson, MSW, ACM, CMAC

Health equity has been a central aim of public health for decades, yet recent political, legal, and regulatory developments threaten its foundations. Although health disparities have long existed, recent changes in federal policy, judicial rulings, and health care priorities risk not only halting progress but also reversing it. For case managers, licensed professionals charged with coordinating patient-centered care across complex health care delivery systems, this reversal introduces ethical dilemmas. Drawing on federal regulatory trends, landmark judicial decisions, and the systematic withdrawal of equity-centered health care programs, this article outlines how case managers can uphold core ethical standards in an era of uncertainty and change. By examining the historical rise of health equity and the counter influences that were occurring simultaneously, one can better understand the factors that have led to the dismantling of equity provisions. Amid these converging factors, case managers must ethically respond to and advocate for the populations they serve.

Understanding Health Equity and Social Determinants of Health

According to the Centers for Disease Control and Prevention (CDC), health equity is defined as "the state in which everyone has a fair and just opportunity to attain the highest level of health" (2024). Specifically, health disparities are considered the preventable differences in health outcomes that adversely affect marginalized groups. Health equity requires the removal of obstacles such as poverty, discrimination, and their consequences, including lack of access to good jobs, education, housing, safe environments, and health care. Thus, achieving health equity requires addressing social determinants of health (SDOH), which are the non-medical factors that influence health outcomes.

The Healthy People 2030 initiative of the US Department of Health and Human Services (2025) includes economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. For example, a patient without access to reliable transportation may have difficulty attending medical appointments, leading to worsening of chronic conditions. In the digital era, additional determinants, such as digital access and literacy, have emerged, sometimes described as "techquity." These include broadband availability, access to digital devices, and the ability to use telehealth tools effectively (Fink-Samnick, 2023). The COVID-19 pandemic further exposed the fragility of health care access among digitally marginalized populations.

Historical Foundations and Policy Evolution

Efforts to promote health equity can be traced back to early public health movements, but modern policy initiatives gained traction during the Civil Rights era. Research by Yao et al. (2019) revealed how academic literature and policy discourse increasingly centered on racial, ethnic, and socioeconomic disparities. Since the early 2000s, the United States has experienced a pivotal shift in recognizing and addressing racial and ethnic health disparities. These efforts have been driven by a growing awareness of how structural inequities and SDOH shape outcomes across diverse communities. The timeline of federal policy, public health crises, and evolving clinical understanding paints a complex but increasingly urgent picture of health equity in America.

Starting with the Bush administration, in 2000, a critical step was taken with the passage of the Minority Health and Health Disparities Research and Education Act. According to Kaiser Family Foundation (2024), this legislation created the National Center on Minority Health and Health Disparities, later elevated to institute status as the National Institute on Minority Health and Health Disparities (NIMHD) under

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The result has been a complicated political environment in which the equity agenda is viewed through competing lenses: one of justice and structural reform, and another of resource scarcity and national identity.

the National Institutes of Health. This move was a federal acknowledgment that eliminating health disparities required not just public will but also dedicated research infrastructure to study and address the underlying causes of inequity.

Building on this foundation, the Institute of Medicine's 2003 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* became a watershed moment. The report detailed how implicit bias, discriminatory practices, and structural barriers within the US health care system contributed to disparate care and outcomes for people of color. It highlighted the persistence of racial disparities even when controlling for insurance status, income, age, and severity of health conditions.

The passage of the Affordable Care Act (ACA) in 2010 further transformed the landscape. Although the ACA is often recognized for expanding insurance coverage, its provisions went far beyond that. It institutionalized equity-focused initiatives and expanded Medicaid eligibility, and required the collection of demographic data to better understand and respond to disparities. The law also strengthened the role of the National Institute on Minority Health and Health Disparities (NIMHD) and encouraged innovation in care models that integrated social needs, such as housing, food insecurity, and transportation into the medical setting. As the decade progressed, Medicaid became an increasingly important vehicle for addressing SDOH through Section 1115 waivers and state innovations (KFF, 2024). States began implementing programs to provide housing support, community health worker interventions, and behavioral health services.

The COVID-19 pandemic brought these longstanding disparities into sharp awareness with the Black Lives Matter movement. Black, Hispanic, and American Indian/Alaska Native populations experienced significantly higher rates of infection, hospitalization, and death. The pandemic catalyzed new public consciousness around the consequences of systemic racism in health care and the need for urgent reform. However, despite the progress made, challenges continued to remain.

But, this trajectory shifted significantly during the Trump administration. Efforts to repeal the Accountable Care Act (ACA), executive orders on immigration, including the Muslim travel bans and heightened border enforcement under Title 42 created barriers to health care for marginalized communities. The COVID-19 pandemic further exposed these inequities, especially among communities of color (Drake & Rudowitz, 2022). The 2022 Dobbs v. Jackson ruling by the Supreme Court, overturning Roe v. Wade, was the first clear sign that an alternative voice was pushing back on democratic health care agendas. This ruling removed the federal protections for reproductive rights related to abortion services disproportionally impacting women and people of color. As the country continued to divide politically, the Biden administration entered office amid the confluence of public health crises, deepening economic divides, and a reckoning with systemic racism. In response, the administration again made health equity a central priority, aligning federal agencies, pandemic response efforts, and Medicaid policy to address SDOH.

One of the administration's earliest acts was Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government." This directive required every federal agency to conduct internal equity assessments and develop actionable plans to address disparities in access and outcomes. It marked a shift from siloed equity efforts to a whole-of-government approach. In health care, this translated into renewed investment in the NIMHD, expanded data collection on race and ethnicity and equity benchmarks built into the operations of the Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and Centers for Disease Control and Prevention (CDC) (US Executive Order of the President, 2023).

However, while equity initiatives gained momentum, the political landscape was shifting. A dramatic rise in immigration, particularly at the US–Mexico border, sparked bipartisan concern over national resources, social services, and public safety. These tensions spilled into traditionally liberal or swing areas, where some voters began aligning with more conservative stances on immigration and public spending. This created fear of economic displacement, crime, and cultural change amplified through media narratives, leading to an electoral shift among some Latino voters in border regions and working-class neighborhoods.

The result has been a complicated political environment in which the equity agenda is viewed through competing

The implication is that hospitals and case managers may no longer be incentivized, or even supported, in their efforts to address patients' socioeconomic needs.

lenses: one of justice and structural reform, and another of resource scarcity and national identity. As a result, the country has experienced a marked swing to the political right, complicating the long-term sustainability of equity-centered policies. The most notable shift was the negative spin on the historical term, *woke*. Beginning in 2023, political rhetoric increasingly targeted programs and policies labeled as *woke*. Originally an African American slang term from the 1930s signifying social awareness, *woke* became a pejorative term in political discourse. It was increasingly used to describe diversity, equity, and inclusion (DEI) initiatives, LGBTQ+ rights, gender-affirming care, and other policies supporting marginalized communities (Monantaro, 2023).

As a result, there has been a systemic effort to defund or dismantle such programs. Since the short start of the second term for President Trump, federal grants aimed at researching marginalized communities were revoked. DEI departments across academic and public health institutions were dissolved. Protections previously shielding hospitals as "sensitive locations" from immigration enforcement were removed, allowing US Immigration and Customs Enforcement (ICE) to operate in clinical spaces.

The LGBTQ+ community has also seen dramatic policy shifts. Gender-affirming care has been outlawed or restricted in several states, with particular focus on minors, and federal documentation no longer includes inclusive gender categories (Cattani & Thompson, 2025).

In April 2025, CMS released its FY 2026 Inpatient Prospective Payment System (IPPS) proposed rule, prompting widespread concern in the case management community. Among the changes proposed were the removal of the four equity-related measures from the Hospital Inpatient Quality Reporting (IQR) Program (CMS, 2025):

1. Hospital Commitment to Health Equity
2. COVID-19 Vaccination Coverage Among Healthcare Personnel
3. Screening for Social Drivers of Health
4. Screen Positive Rate for Social Drivers of Health

Similarly, the CMS proposed the removal of SDOH-related requirements from Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs). Instead, a shift in focus was noted towards general health and wellness, without concrete mechanisms for addressing disparities. This reversal effectively invalidates recent progress in capturing, reporting, and responding to SDOH data. The implication is that hospitals and case managers may no longer be incentivized, or even supported, in their efforts to address patients' socioeconomic needs.

Ethical Implications for Case Managers

The CMSA Standards of Practice for Case Management (2022), the Commission for Case Manager Certification Code of Professional Conduct for Case Managers (April, 2023), and the Certified Disability Management Specialist Code of Professional Conduct, (April, 2023) identifies five foundational ethical principles:

1. Autonomy – Respecting the patient's right to make informed decisions
2. Beneficence – Acting in the best interest of the patient
3. Fidelity – Being truthful and faithful to the patient-provider relationship
4. Justice – Treating individuals equitably and with fairness
5. Nonmaleficence – Avoiding harm

Navigating the current political landscape requires not only clinical skills but ethical vigilance. The removal of tools like SDOH screening requirements creates an ethical dilemma: how can case managers continue to advocate effectively for patients when institutional mechanisms are weakened?

This poses a risk to case managers who must navigate a changing political direction away from social inequities while also managing the clear needs of their patients. In efforts to ensure non-maleficence, case managers must balance their own moral distress, between knowing the right action to take but constrained by external limitations. Consider a scenario where a patient lacks stable housing, but the hospital no longer supports a structured SDOH assessment. Without documentation or workflow to refer to shelter placement, case managers are left with unmet ethical obligations and an increased emotional burden. Case managers must rely on their standards of practice for thorough assessments, which prior to the mainstream terminology of SDOH, included questions related to housing, transportation, utilities, and "barriers" were already in use. By retaining case management principles for psychosocial assessments and addressing

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barriers to care, case managers can ensure justice for their patients outside of any political mandates or changes.

In response to these challenges, case managers must reaffirm their ethical role not only as care coordinators but as advocates. As these changes continue to unfold, case managers should maintain an internal dialogue to discuss rising ethical concerns and how they will be addressed within their organization. Patient stories highlighting unmet social needs and data collection, despite policy requirements, provide compelling arguments for the objective connection between social risk factors and health outcomes. Case managers should consider how they can participate in policy engagement through their national associations to stay alert to the proposed rulings and enacted changes.

Health equity is at a crossroads. While historical progress brought attention and resources to addressing disparities, recent regulatory and political shifts present serious threats. Case managers now operate in a context where tools and policies that once supported their advocacy have been removed or diminished. Yet, the ethical imperative remains unchanged. Case managers must commit to their professional values and engage in collective advocacy to preserve health equity as a foundational pillar of health care delivery. CE II

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Slicing Through Complexity: The PIE Model™ for Care Management and Aging Patients

By Nancy Ruffner

Introduction: Slicing Through Complexity with The PIE Model™

Those of us in care management know it's rarely just one issue we're helping a client navigate. It's overlapping needs—medical decisions, legal planning, financial strain, insurance confusion, housing transitions, and emotional or practical support. And in the middle of it all? The case manager, tasked with making sense of the whole picture.

That's what led me to create The PIE Model—a six-slice framework (Medical, Legal, Financial, Insurance, Housing, and Support) to organize and track the complexities of health-related transitions. What began as a simple visual aid evolved into a go-to tool for structuring workflows, guiding family meetings, and training care professionals.

It's not a theory. It's a tool. You can jot it on a notepad, share it with a care team, or use it to steady overwhelmed families. It adapts well to formal assessments, interdisciplinary meetings, or casual check-ins—and offers a shared language for what's often a scattered, emotional process.

In this article, I'll introduce The PIE Model, outline its six slices, and explore how it applies across care settings. Whether coordinating a discharge or planning long-term care, PIE can help your team and clients move forward with greater clarity and confidence.

The PIE Model in a Nutshell

The PIE Model is a practical framework to help care professionals and clients navigate life's most complex transitions—especially those involving aging, health changes, or caregiving. It breaks big, overwhelming situations into six manageable "slices": Medical, Legal, Financial, Insurance, Housing, and Support.

The idea is simple: instead of reacting to issues as they arise, the PIE Model gives us a structure to anticipate, assess, and address them proactively.

The idea is simple: don't just react—anticipate, assess, and act. The PIE Model offers a clear structure for proactive planning. For example, with a newly diagnosed client, a care manager might ask: What's happening medically? Are legal documents up to date? How will care be funded? What insurance benefits apply? Is housing still a fit? Who's in their corner to help?

Each slice interacts with the others. A hospitalization, for instance, might trigger legal updates, insurance questions, and support needs. The PIE Model makes those ripple effects visible—and manageable.

The model can be adapted for a wide range of uses:

- **Assessment tool:** Identify gaps, set priorities, track change
- **Conversation guide:** Break down complex topics, surface key questions
- **Teaching tool:** Train staff, students, and caregivers using real-life structure
- **Collaboration map:** Clarify roles and coordinate care across disciplines

It's visually friendly—easy to sketch, post, or present. Professionals use color-coded versions to track care plans, document progress, and simplify family meetings. It brings clarity and reduces conflict.

The PIE Model brings everything to the table without overwhelming anyone. Clients appreciate the clarity. Professionals value the coverage. Teams rally around the shared language. It helps ensure nothing's missed.

The PIE Model doesn't replace other care frameworks—it complements them. Think of it as the sturdy plate that keeps the care plan balanced so nothing slides off when life gets messy.

The Six [PIE] Slices: A Closer Look

Let's walk through each of the six slices of The PIE Model, keeping in mind that they often overlap in real life—and that's exactly why a model like this proves useful. When we understand each domain individually, we're better equipped to spot the domino effects that can cascade through the rest.

Nancy Ruffner *works at the intersection of aging, strategy, and advocacy. Known as a Subject Matter Expert in Solo Aging and now The PIE Model,™ she consults, teaches, and speaks nationally to elevate care approaches.*

The idea is simple: instead of reacting to issues as they arise, the PIE Model gives us a structure to anticipate, assess, and address them proactively.

"The use of a structured method led to a higher performance level... because of its holistic approach, integrating conception, planning, and action into a coherent cycle" (Bußwolder, 2015).

Medical
The Medical slice addresses health status, diagnoses, treatment plans, medications, and providers involved in care. But it's also about communication—between specialists, with the primary care provider, and with the client and family. This slice prompts us to ask: What's the current condition? What's the trajectory? Are care goals aligned and understood?

Legal
This slice includes advance directives, powers of attorney, wills, guardianships, and other documentation that supports autonomy and safety. For professionals, it's not about giving legal advice—it's about knowing whether appropriate tools are in place and who has the authority to act. Gaps here often surface only in a crisis.

Financial
Finances can determine what options are even on the table. This slice includes income sources, expenses, savings, and planning strategies, as well as access to benefits. Can the client afford in-home care? What about long-term care? Are they vulnerable to financial exploitation? This slice helps us consider both the short-term picture and long-term sustainability.

Insurance
Health insurance, long-term care insurance, life insurance, and even property or disability policies fall into this slice. Here, the focus is on coverage fit: What's available, what's not, and what needs clarification or advocacy? This area often reveals opportunities to activate underused benefits or identify coverage risks that need to be addressed.

Housing
This slice invites exploration of whether the current living situation still works. Is it safe? Accessible? Sustainable? Whether we're talking about home modifications, downsizing, or a move to supportive housing, this domain brings function, safety, and emotional well-being into focus. It also includes conversations around future needs and preferences.

Support
Support can mean a lot of things: family, friends, neighbors, faith communities, service agencies, or case managers. This slice looks at who's showing up, who's stretched thin, and where reinforcements are needed. It's not just about having people "around"—it's about building a sustainable circle of care, team, or community.

Together, these six slices create a full picture. And once that picture is clear, next steps become easier to name, share, and digest.

Case Example: Mr. Jim—When Every Slice Matters

Mr. Jim was in his 80s, a widower with advancing Parkinson's disease. He'd moved into a well-regarded independent living community, reassured by its promise of "aging in place, and to End of Life." On-site home care, therapy services, and a contracted primary care physician gave the appearance of a comprehensive setup. But as time went on, gaps began to widen.

Mr. Jim's cognitive function was already declining when he moved in. He had fallen victim to home repair scams, losing over $100,000. Though he had completed estate planning—including placing land in trust—he hadn't spoken with his financial advisor in years. (It was later discovered that the advisor had died seven years earlier). His daughter lived nearby but was largely absent. Facility staff saw her as aloof, even indifferent. In truth, she was overwhelmed: holding down a high-stress job, working to stabilize her marriage, and adjusting to her young child's newly diagnosed special needs.

Mr. Jim began experiencing frequent falls, some with injuries. As per community policy, each incident triggered an emergency room visit via ambulance, followed by a return to the same living environment. At $15,000 per month, the facility's services were increasingly costly, yet no one had suggested a transition to a higher level of care.

When a professional case manager was called in to "help manage his medical care," it quickly became clear that this wasn't just a medical issue. It was a full PIE.

- **Medical:** No neurologist was involved. His Parkinson's was being managed in isolation by a generalist. Referrals to a

When we understand each domain individually, we're better equipped to spot the domino effects that can cascade through the rest.

Parkinson's Center of Excellence and geriatric specialists were made to better understand his condition, plan for changes and reduce ER reliance.

- **Legal:** His documents were generally in place, but no one had reviewed them recently. Power of Attorney needed to be clarified and activated.
- **Financial:** As bills mounted, a review revealed the inactive LTC policy, which was ultimately engaged to offset housing and care expenses. There was also a need for financial cleanup after the scam losses and to install day-to-day money management.
- **Insurance:** The long-term care policy had never been launched. With advocacy and documentation, the benefit was activated and began paying out, easing the financial strain.
- **Housing:** It became clear the facility could no longer safely meet his needs, despite their promises. A transition plan was made, balancing Mr. Jim's wishes with safety and affordability.
- **Support:** Mr. Jim was increasingly isolated. The case manager coordinated transportation so he could resume attending his faith community—something he'd dearly missed. His daughter, after receiving education and support, re-engaged and began making meaningful, empowered decisions through her POA role. Though his estranged son never reappeared, Mr. Jim built a meaningful relationship with his granddaughter before he passed.

This wasn't a rescue mission. It was realignment. PIE revealed what was already happening—and what was being missed.

When Mr. Jim died, it was that faith community who celebrated and buried him. Much of Mr. Jim's "team" lined the pew, the collaborators there either in person or represented. It was a powerful image of the intentional wraparound care that had been built. His daughter was able to remain active in her own family's life and looks back on her father's final chapter with peace rather than regret.

Using the PIE Model in Everyday Case Management Practice

Case managers wear a lot of hats—interpreter, coordinator, bridge-builder, advocate. The PIE Model helps us wear them well. It brings structure to complex situations, making it easier to assess, explain, and act. In Mr. Jim's case, PIE turned chaos into clarity—for the case manager, the client, and everyone else involved.

Family and Client Education

Families don't always arrive with a shared understanding of what's going on—or what needs to happen next. The PIE Model offers a plain-language roadmap. It turns overwhelm into organized action.

Mr. Jim's daughter wasn't disengaged out of apathy—she was overwhelmed. Sitting with her and walking through the six PIE slices brought a moment of clarity. She saw this wasn't just a "medical" issue, but also one involving financial gaps, legal questions, insurance complexities, and support needs.

PIE helped her step into a more active role. For Mr. Jim, even during cognitive fog, we could point to the visual and say, "Today we're just working on this slice." That brought dignity and agency back into the process—two things often missing when people feel lost in a system.

Cross-Sector Collaboration

Mr. Jim's team became a mosaic of helpers, brought together and guided by a ***professional case manager***—with PIE as the organizing principle:

- An ***attorney*** refreshed POA and estate documents.
- A ***Daily Money Manager*** tackled routine financial tasks.
- A new ***financial advisor*** was briefed and brought on board.
- ***Housing staff*** were trained to better distinguish medical vs. behavioral changes.
- ***Therapists*** coordinated with housing on safety and IADLs.
- A ***Parkinson's Center of Excellence*** joined the care team.
- A ***home care aide*** became a trusted companion and communication bridge.
- His ***faith community*** offered vital emotional support to Mr. Jim and his family.

Each provider saw where they fit, thanks to PIE. It kept communication focused, efforts aligned, and Mr. Jim at the center.

Just as crucial, the case manager helped reconnect Mr. Jim with his daughter—not just emotionally, but practically. With PIE as the translator, she grew into her role as proxy

Together, these six slices create a full picture. And once that picture is clear, next steps become easier to name, share, and digest.

and decision-maker. Over time, the reins could be transferred. Continuity remained, even as dependency on the care manager faded.

Team Onboarding and Supervision

Bringing in new professionals can create a learning curve. PIE flattens it. It shows what's been addressed, what's in motion, and what needs work—at a glance.

It also shines in internal supervision. During Plan of Care reviews, PIE helps assign responsibilities by slice instead of bouncing from one concern to the next:

- One person handles insurance claims and policy activation.
- Another coordinates social and spiritual support.
- Someone else oversees medical logistics or transportation.

In Mr. Jim's case, onboarding worked both ways. The team learned about Mr. Jim, not just as a "Parkinson's patient" or a "fall risk." He was Mr. Jim, a grandfather who wanted to stay connected to his church and his family, and each action taken reinforced the whole.

Why It Resonates (and Works) with Professionals and Clients

The PIE Model lands. It's simple but not simplistic, and comprehensive without being overwhelming. Professionals often say, "This is how I already think, but now I have a way to explain it." Clients tell me, "I finally get it."

That response isn't just verbal—it's visible. There's often a moment, almost a physical shift, when I introduce the model. Listeners pause, then light up. As one professional later wrote, "I was stopped in my tracks when you described your 'pieces of pie' approach to holistic client care. It's such a powerful framework."

When I sketch the PIE during a session, clients lean in. Professionals exhale. Suddenly, we can hold the whole situation in view—and begin to sort it out. To support this clarity, I created a set of labeled illustrations: one for the whole PIE and one for each slice. These visuals consistently spark understanding faster than a paragraph ever could.

It turns out there's science behind that "lightbulb moment." Visuals can improve learning by up to 400% (The Educator K/12, 2022). They also enhance knowledge transfer and long-term retention compared to words alone (Eyler & Cavanaugh, 2021). That's why PIE resonates: it turns complexity into something people can see, grasp, and act on.

And that's critical, because we've all seen what happens when one slice gets all the attention. A solid medical plan can still collapse if housing is unsafe. Friends may offer support, but without legal documents, big decisions stall. PIE helps make the case that it's never just one thing.

Vision for the Future

The PIE Model wasn't born in a think tank—it came from the messy, beautiful complexity of real life. That's part of why it works. It reflects how people actually experience their needs: layered, interconnected, and often hard to name.

From the start, PIE was meant to be practical and shareable—a tool professionals can use right away to organize, prioritize, and improve outcomes. It's both a planning framework and a communication bridge. When we can same-page a client, care team, and family in moments—that's not just clarity—that's efficiency.

Interest is growing. Invitations continue to come from conferences, webinars, and community talks. Professionals across disciplines—care managers, social workers, clergy, attorneys—are looking for better ways to "see the whole picture."

So, what's next? Bigger reach. Broader adoption. PIE baked into the workflows of care delivery—not as an add-on, but as a go-to.

PIE can help teams evaluate services, spot gaps, and unify intake and assessment processes. Its simplicity makes it scalable across sectors. Organizations, not just individuals, can benefit—from solo practices to hospital systems.

There's strong potential for integration into care management training, onboarding, and interprofessional education. As care grows more integrated, tools that offer shared language and structure become essential. PIE meets that moment.

Even adjacent industries are taking notice. Financial planners, elder law attorneys, insurance agents, and housing professionals all see how PIE helps them talk with clients about whole-life planning. In a siloed world, PIE offers a bridge—not just across professions, but into people's lives. It helps the helpers help.

Future directions include companion tools: a workbook in development, PIE-organized intake forms set for pilot

testing, and short videos for onboarding, education, and engagement. Formal trainings and deeper dives into the six domains are also on the horizon.

PIE wasn't built to be licensed or locked down. It's meant to be shared—with attribution—so others can adapt it, use it, and improve outcomes. Wider use invites refinement, data collection, and collaboration.

Turns out, I'm not the only one thinking this way. As CMSA's former president Dr. Colleen Morley said:

"Simply put, I believe and advocate that it is our right and responsibility to disrupt processes when they are not working and propose new and innovative solutions to the issues we identify" (Morley, 2022).

That's what PIE is: a smart disruption. Engaging, effective, and easy to digest—for professionals, clients, and care teams alike.

As more professionals adopt it, PIE becomes more than a model—it becomes momentum. It keeps proving what I suspected all along: there is a clearer, more engaging path to better outcomes. And sometimes, it starts with something as simple—and powerful—as a slice of PIE.

Conclusion: A Call to Action

The PIE Model began with a simple truth: the needs of individuals—and the teams who support them—are layered, connected, and often overwhelming. We've all faced that moment when a client's situation feels like too much: too fragmented, too foggy, too fast. PIE offers structure without rigidity, clarity without complexity. It simplifies without dumbing down, organizes without overwhelming, and opens conversations that might otherwise never happen.

Whether you're a care manager, clinician, family caregiver, or individual navigating care, PIE offers a way in—a lens to see the full picture and start charting a course forward. Start with one client. One care conference. One question: "Have we covered the whole PIE?"

Try it. Share it. Fold it into your next interdisciplinary huddle or intake call. You might find that what looks like a modest framework becomes a powerful compass. Clients get it. Teams rally around it. And most of all, it helps ensure no one is left without the support they need.

PIE is meant to be shared.

Not too many people tackle a whole pie alone.

So go ahead. Take a bite. CE 3

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New Exam Blueprint for the Certified Case Manager (CCM) Credential *continued from page 4*

a 1% gain from 2019 and 2014. This finding is evidence of the continued recognition of the value of certification among a significant percentage of employers.

- Professional diversity continues to increase among case managers. At 79% of respondents, nurses remain a large and important professional segment of case managers (compared to 82% in 2019). Social workers now account for an increasing portion of case managers at nearly 12% of respondents in 2024, compared to less than 6% a decade earlier. Respondents with a vocational rehabilitation or disability management background accounted for a total of 3.2% of respondents, compared to 1.6% in 2019.

Learning More About Certification and the New Exam Blueprint

The 2024 job task analysis captures the dynamics of case management as practiced today across health and human services. For those who are pursuing board certification, the latest research findings reveal the scope of required knowledge. (More can be found in the newly updated Certification Guide to the CCM Examination. Or tune into CCMC's Take a Listen podcast, available on Spotify, which includes a new episode, entitled The State of Case Management: Inside the 2024 Job Task Analysis.)

For professional case managers who are already certified, including those who have held the CCM credential for many years, emerging trends in the field can inform their areas of focus when pursuing continuing education. As a reminder, to be eligible for renewal, board-certified case managers must complete 80 hours of continuing education, including 8 hours related to ethics.

As the case management profession continues to expand, incorporating more backgrounds and areas of specialization in health and human services, certification establishes important common ground. By staying current and capturing relevant insights through rigorous research, the Commission upholds its long-standing tradition of ensuring the relevance of the CCM credential. CM

Innovation: Can Each Case Manager Become an Innovative Leader? *continued from page 3*

provide, and, of course, the outcomes you obtain. Seeking feedback from providers and colleagues who you interact with is also beneficial and can provide you with valuable insights into where improvements are needed. This practice will also encourage you to adopt a proactive stance toward adopting new methodologies. This is extremely important, especially for senior professionals because the tendency is to assume that experience is what matters most when, in fact, newer strategies might be even more effective.

- **Network Widely and Smartly:** Networking isn't just about exchanging business cards or for those case managers who work remotely. You might not think there are opportunities for you to network; however, while more challenging, it is possible. Through online blogs and forums, Team Meetings, professional journals, and webinars, industry experts and thought leaders can be identified. Reach out to those individuals and don't be afraid to contribute your unique expertise and strategic intervention that has been successful for you! Look for opportunities to attend local or regional conferences; while it may feel more comfortable to attend the sessions that reflect your own practice and experience, it's a better learning opportunity for you to step outside your comfort zone and attend sessions where you have minimal knowledge and experience because that's where learning begins!

As we approach the ending of the leisurely months of Summer, I hope you have had some opportunities to enjoy this special time with family and friends and can return to your case management responsibilities with renewed energy and a desire to explore some innovative strategies that will improve the outcomes and lives for your patients, while providing you with a greater sense of fulfillment in your case management career!

You can make a difference, one patient at a time!

Warmest regards,

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

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continued from page 7

addition to the obvious potential problems for quality of care related to the use of these functions, auditors are understandably skeptical of documentation that repeats itself throughout patients' medical records.

Auditors are especially likely to deny claims that include documentation that was obviously copied using the above functions, when the information copied "sticks out like a sore thumb." If hospice staff document, for example, that "the patient eats a lot of Mexican food" over and over in clinicians' visit notes, auditors are understandably skeptical about whether services were necessary for a hospice patient who seems to have a continuous robust appetite or whether services were, in fact, rendered.

What does it mean to "paint a picture?" If a home health patient needs wound care or injections of medications, for example, the "picture" must account for why patients or their caregivers are not performing these activities themselves. Clinicians need to describe the following in a "picture" of the patient:

- Does the patient live alone or have caregivers?
- Why can't the patient do wound care or self-inject medications?
- Why can't caregivers perform these activities?
- What attempts did clinicians make to assist patients and caregivers to provide wound care and injections?
- Why were these attempts unsuccessful?
- What attempts were made to find other caregivers—either paid or voluntary—who might provide these types of care?
- What were the results of these attempts to find other caregivers?
- Despite the initial inability of patients and caregivers to render this care themselves, what efforts did clinicians make to help ensure that they became able to do so?

You get the picture. It's difficult, if not impossible, to paint the above picture using only the boxes and blanks of forms in EHRs. More is needed if providers are serious about positive audit results. CM

Celebrating Case Managers at CMSA *continued from page 5*

families. Speakers include Dr. Melanie Prince, Dr. Raine Arndt-Couch, and a panel of military case managers.

From Nashville to virtual conference rooms, from Boot Camp basics to high-level leadership, CMSA is proud to bring you a celebration filled with learning, growth, and networking. CMSA is honored to recognize and celebrate the case management profession. We are committed to helping case managers thrive in their role by providing quality education and resources. Many of these events come with exclusive perks for CMSA members, including discounted or free registration, access to session recordings, and bonus resources. If you are not a member yet, now is the perfect time to join and get the most out of CMSA's fall offerings! CM

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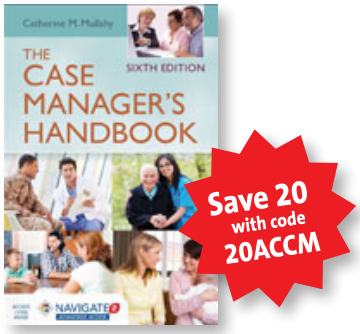

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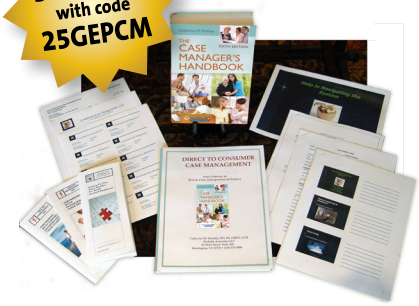

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